THE CHALLENGE OF AIDS:

A NOVA SCOTIAN RESPONSE

Report of the Nova Scotia Task Force on AIDS

Nova Scotia
Province of Nova Scotia

89-00444/

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Submitted to the Minister of Health and Fitness

September 1988

Nova Scotia

Task Force on AIDS

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The Honourable Minister of Health and Fitness
Province of Nova Scotia

Dear Mr. Minister,

On behalf of the Nova Scotia Task Force on AIDS, I submit to you for the consideration of the Executive Council our final report, *The Challenge of AIDS. A Nova Scotian Response*.

We have had the opportunity to study and reflect upon the spread of AIDS, now a worldwide problem, and the human tragedy it has wrought within segments of our society. We have been enriched and we have been deeply moved by the circumstances we have encountered. We have come to recognize the difficulties involved in dealing with a health condition which is still unfamiliar, is invariably fatal and is often perceived as associated with lifestyles which are not widely accepted.

AIDS is not now widespread in Nova Scotia. Yet this province is not isolated from the larger world. Since symptoms of AIDS may not appear for some years after infection with the Human Immunodeficiency Virus, we do not know the current incidence of HIV infection in Nova Scotia.

Yet we are heartened to learn that the virus is transmitted in very few ways and that informed persons can prevent its transmission with simple precautions. For this reason, we emphasize the significance of and the need for public education at this time. We believe that policies and programming for public schools and educational institutions, already announced by government in response to interim recommendations of the Task Force, are important beginnings.

We are confident that Nova Scotia's health care and social service systems, with modest modifications such as enhanced AIDS education for care providers and the integrated home care system now being established, can meet the needs of persons infected with HIV or those who develop AIDS. Recommendations in the report reflect this concept, that services for those afflicted be integrated in and not separated from our general health care and social service programs.

AIDS, although principally a medical problem, cannot yet be dealt with as just another medical condition, ignoring the social concerns which it has raised. The evolution of a public consensus to deal with the complex social problems arising from AIDS will require reasoned and knowledgeable argument informed with tolerance, compromise and unreserved compassion.

On broader social issues affecting human rights, we have sought to balance the interests of the public-at-large with those of the individual, recognizing that respect and concern for the individual are keystones of our society. Ensuring the rights of individual Nova Scotians will minimize the negative impact AIDS might have on our society.

There is a constructive side to the AIDS phenomenon which should not be ignored. AIDS has given us a new impetus to reconsider many practices. In our health care services, we are considering the place of holistic medicine, home care and palliative care for the terminally ill, and we are emphasizing guidelines and practices for infection control. In regard to other matters, we are taking a more open approach to education about human sexuality, at least for our children, and we are re-evaluating our attitudes towards unreasonable discrimination.

We recognize that the challenges AIDS presents will continue to evolve and that legislation has been enacted to create a continuing Advisory Commission on AIDS. Our report does not address all of the specific issues raised during the public meetings of the Task Force. The intent of our report is to share with Nova Scotians what has been learned about AIDS, to encourage informed discussion and, through our recommendations, suggest principles for meeting the challenges of AIDS. We hope our report provides an agenda for discussion and for action.

AIDS is a challenge for all of us, but a challenge which can be met. This will require the best effort in each of us. It will require leadership by governments, business, labour and the voluntary sector, whose activities should be co-ordinated.

On behalf of the Task Force, may I acknowledge the invaluable assistance we have had in our work from the many Nova Scotians who contributed during public meetings, and by information, advice and comment provided outside these meetings. I also thank the many people outside the province who shared their experience and their views with us.

May I acknowledge as well the importance of the initiatives already undertaken by the Government of Nova Scotia and the continuing assistance in support of our task by public servants, especially in the Department of Health and Fitness. The contribution of the Federal Centre for AIDS of the Government of Canada in providing much general advice, and financial support for particular aspects of our work, is greatly appreciated.

May I acknowledge for all members of the Task Force the work of the staff who supported us. As Chairperson, I thank my colleagues who served on the Task Force for the time and the interest they have devoted to our work.

We are confident that as Nova Scotians come to understand the facts about AIDS, they will work together to support policies and programs which are reasonable, enlightened and compassionate.

Respectfully submitted,

W. Andrew MacKay
Chairperson

September, 1988

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2. **Reports of Task Force members on visits to other cities and countries:**

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   San Francisco and Vancouver
   by Dr. Wayne Sullivan and W. Barbara Carbonell

   Boston
   by Marlene Grantham

2. **Summary of Recommendations and Comments from Public Meetings**

3. **Listing of persons interviewed or consulted during preparation of the Nova Scotia Task Force on AIDS report**

4. **A description of video prepared to accompany the final report of the Nova Scotia Task Force on AIDS**

5. **Papers commissioned by the Nova Scotia Task Force on AIDS:**

   A Study of Attitudes and Beliefs About AIDS in Nova Scotia for the Nova Scotia Task Force on AIDS
   – by Decima Research Limited

   The Influence of Victim and Respondent Characteristics on Attitudes towards AIDS: A Report to the Nova Scotia Task Force on AIDS
   – by students from Mount Saint Vincent University

   AIDS: In Search of a Public Policy Response
   – by Dr. Barry Lesser

   Public and Private Health and Care Services: Report to the Nova Scotia Task Force on AIDS
   – by Dr. Lynn McIntyre

   Living with AIDS – The Reality
   – by the Nova Scotia PWA Coalition

   The Pastoral Care of Persons with AIDS: "Perfect Love Casts Out Fear"
   – by Reverend Robert Petite

   Teaching Children Hygienic Procedures to Reduce the Risk of Infection
   – by Psychology Department, Izaak Walton Killam Hospital for Children

The Challenge of AIDS

The Acquired Immune Deficiency Syndrome (AIDS) is not as widespread in Nova Scotia as it is in many other places. But Nova Scotia is not isolated from the larger world, and AIDS is among us -- a new and fatal syndrome caused by the Human Immunodeficiency Virus (HIV), which is primarily sexually-transmitted.

AIDS has created a series of challenges which test our values as individuals and as a society. To the extent that we meet these challenges successfully, we will develop a society which is more responsible, honest, tolerant and compassionate.

AIDS challenges our sense of individual responsibility. There is for now no vaccine or cure nor any other direct way for government or society as a whole to control the transmission of HIV. Every individual is responsible for learning the facts about AIDS and altering his or her behavior accordingly. Society must provide the information and education necessary to help citizens understand how to prevent further spread of the virus.

AIDS challenges our compassion. We must not allow unfounded opinion, prejudice or fear to blind us to our duty to care for our friends and neighbours who have been stricken. For their sake, as well as our own, we must understand the facts about AIDS.

AIDS challenges our sense of community. The syndrome has been linked with persons who have been stigmatized in some societies, notably male homosexuals. This has sometimes led to condemnation and judgement of people infected with HIV, rather than the sympathy and consideration we have traditionally shared as friends, neighbours and fellow human beings.

AIDS challenges our courage, because we must stand up for those who are infected with the virus to ensure that their rights, and by extension our own, are protected.

AIDS challenges our honesty, because we must learn to speak openly about sexuality, particularly to the young. When lives are at stake, there is no place for embarrassment.

AIDS challenges our sense of proportion and powers of reconciliation. It demands responses which avoid the extremes of panic and complacency. Policies relating to AIDS must reconcile competing value systems and interests which are perceived to be in conflict.

AIDS challenges our foresight. We must build a consensus supporting the policies and programs necessary to prevent further transmission of the virus while protecting the rights of those who are infected. This will require a long-term process of education.

The Nova Scotia Task Force on AIDS is confident Nova Scotians will meet the challenges posed by AIDS. Nova Scotia is a close-knit and caring community. We believe that as Nova Scotians come to understand the facts about AIDS and know the suffering it causes, they will respond with the thoughtfulness and kindness which are the hallmark of our society. We believe Nova Scotians will do all they can to ease the suffering of those with AIDS, educate themselves to prevent further transmission of the virus and protect the political values from which all of us benefit.

The problems posed by AIDS will not be resolved with the publication of any report or the implementation of any particular set of policies. We will deal effectively with these challenges only through the continued vigilance of individuals in protecting themselves and their partners in humankind's most intimate relations, and through supporting those infected with HIV as full members of our society.

I: Putting the AIDS Crisis in Context

1. A Remarkable Consensus

A remarkable consensus, led by the world scientific community, has developed on the basic facts about AIDS and how government policies should respond to AIDS.

A consensus on the facts.

While it is true that important questions about the syndrome remain unanswered, there is strong agreement among the world's scientific community that:

- AIDS is caused by a virus called the Human Immunodeficiency Virus;
- the virus is spread in only a few, obvious ways;
- fears of transmission through everyday contact are unfounded;
- people can protect themselves and others against infection, and those who are infected can prevent further transmission, by following a few, relatively simple guidelines.

A consensus on policy.

Based on this understanding, a consensus has developed among democratic nations on the appropriate response of government to AIDS. There is general agreement that:

- preventing transmission of the virus is an individual responsibility to which society must contribute education and information;
- universal testing, mandatory testing and quarantine are not useful methods of controlling the spread of HIV;
- there is no public health need to restrict the rights of people who are infected with the virus or to make their condition public, except in very narrowly-defined circumstances;
- people who are infected with the virus have the same rights to compassion, health care and social services as other people.

No conflict between the protection of public health and the rights of infected people.

These are the broad principles on which the Nova Scotia Task Force on AIDS has based its recommendations. As these principles imply, we believe that there is no overriding conflict between the protection of public health and the rights of people who are infected with the virus.

2. The Nova Scotia Task Force on AIDS

Recognizing the need for policies and programs to address the challenge of AIDS, the Government of Nova Scotia, on November 6, 1987, established the Nova Scotia Task Force on AIDS. Under the chairmanship of Dr. W. Andrew MacKay, the Nova Scotia Ombudsman, the Task Force was directed to:

Mandate of the Task Force.

- review existing policies in the public and private sectors;
- study methods of responding with compassion and confidentiality to the needs of people with AIDS, their immediate families and dependents.
- make recommendations on the further strengthening of programs of public education and information.
- make recommendations on further methods to limit the spread of the virus;
- study the best means of promoting co-ordinated action by government and community groups to meet the needs of people with AIDS who require public assistance.
- examine the need for a central AIDS research and information centre;
- define a "need to know" policy with respect to those who work with or provide services to those with HIV infection;
- analyze probable costs of care and treatment.

The Task Force of 21 members represented a variety of associations and provincial government departments with direct involvement in and knowledge of the problems of AIDS. The Task Force was directed to make its report to the Executive Council of Nova Scotia through the Nova Scotia Minister of Health and Fitness. Since the appointment of the Task Force, the Government of Nova Scotia has passed legislation creating a Nova Scotia Advisory Commission on AIDS, which will have on-going responsibility for advising government on policies relating to HIV infection.

Work of the Task Force.

Since the issue of AIDS touches so many areas of public policy, the Task Force divided into three Working Groups, examining legal and ethical issues, information and education, and health and other types of care. The Working Groups in turn commissioned more than 20 research papers.

The Task Force studied programs and policies in other jurisdictions and reports on the issues associated with AIDS, such as those by the Royal Society of Canada and the Presidential Commission on the Human Immunodeficiency Virus Epidemic. Task Force and staff members travelled to the United States, Britain and Australia to study programs of prevention and treatment in those countries. The Working Groups met frequently over a period of nine months, with the Task Force meeting as a whole biweekly.

Among the general issues highlighted during discussions were:

- What general educational programs should be advocated to prevent further transmission of HIV?
- What possible conflicts between public health requirements and the rights of individuals needed consideration and resolution?

- What programs might be needed for special audiences such as intravenous drug abusers, prostitutes and street people, and for preventing HIV infection among the newborn?
- What changes might be needed in the existing health care and social service systems?
- What research might be encouraged?
- What should the priorities be and how should they be set, given limited financial and human resources?
- What suggestions should the Task Force make on the role of the Advisory Commission on AIDS?
- What national and international co-operation should be fostered, given that AIDS is a worldwide phenomenon?

Public meetings held across the province.

The Task Force also held a series of public meetings on AIDS over a period of three weeks in March, 1988. This was the first time in any Canadian jurisdiction that members of the public had such an opportunity to provide input into the formulation of policies relating to AIDS. The meetings were of great value to the work of the Task Force and were themselves a valuable exercise in public education. The Task Force listened to interested groups and members of the general public in Dartmouth, Sydney, Port Hawkesbury, Antigonish, Digby, Yarmouth, Shelburne, Clark's Harbour, Liverpool, Bridgewater, Wolfville, Amherst, Truro, New Glasgow and Halifax.

The Task Force received a total of 99 formal submissions and additional briefs were presented outside the public meetings. Formal presentations in each location were followed by questions and statements from the audience. Throughout, the Task Force was impressed by the work and thought which have been devoted to the issue of AIDS by many people in all regions of the province.

3. The Facts About AIDS

AIDS originally a mystery but a great deal has now been learned.

Following the recognition of AIDS in 1981, there was a period of about two years during which AIDS was genuinely a "mystery disease." Its cause was unknown and there was a great deal of uncertainty about the nature of the syndrome, the manner of its transmission and whom it affected.

But since its recognition, AIDS has been the object of an unprecedented international research effort and a great deal has been learned about AIDS in a relatively short period of time. Although for many the syndrome is still surrounded by an aura of uncertainty, the epidemiological and clinical picture of AIDS is now better understood. We know the disease is caused by a virus and how that virus is spread. We have a reasonably reliable test for the presence of antibodies to the virus and the first drugs are being tested which, for some, may help relieve symptoms.

HIV and AIDS

AIDS is the final stage of infection with the Human Immunodeficiency Virus (HIV).

AIDS – the Acquired Immune Deficiency Syndrome – is caused by a retrovirus called the Human Immunodeficiency Virus, or HIV. As a syndrome, AIDS is not a disease but a specific collection of symptoms, the final and fatal stage of HIV infection.

In lay usage, the word "AIDS" has come to refer to all health consequences of HIV infection. AIDS is in fact the most serious of the many health problems which can be caused by HIV infection. In this report, the term "HIV-related illnesses" is used to describe the full range of health problems caused by HIV. The term "HIV-infected" refers to all persons who are infected with the virus, including those with AIDS.

Viruses are one of the smallest and most primitive forms of life, consisting solely of a strip of genetic material with a protein coat. On entering the body, viruses cause illness by taking over the genetic core of certain types of cells. The target cells are then used to produce new viruses, and in doing so, are themselves killed.

HIV attacks the immune and central nervous systems.

The Human Immunodeficiency Virus principally attacks two types of cells. These are a sub-group of white blood cells called helper-T cells and cells of the central nervous system.

Helper-T cells are a vital part of the immune system by which our bodies recognize, attack and neutralize foreign disease-causing agents. When HIV attacks helper-T cells, the immune system is impaired and the body may ultimately be left unprotected against a variety of cancers and infectious organisms which a healthy person can resist without difficulty. These are known as opportunistic infections because they take advantage of the infected person's weakened immune system.

The spectrum of people who enter the health care system because of HIV begins with those who are at risk of infection, ends with those who die of AIDS and includes a variety of patients with different needs between.

At the beginning of the spectrum are the so-called "worried well", those whose past or current behavior may put them at risk of infection. They are concerned about the possibility of HIV infection and suffer anxiety. The care of these patients includes counselling, possible testing, education and follow-up.

HIV causes a wide variety of health problems.

Those who are infected with HIV may suffer a variety of health problems. As far as is known, for the rest of their lives they will be capable of transmitting the virus to others.

Shortly after becoming infected, some people may experience short-lived, acute symptoms such as fever, swollen lymph glands and fatigue. For some, this occurs within three weeks of infection, for others within six weeks or longer.

These symptoms are usually associated with the development of antibodies against HIV (called "seropositivity"). It is these antibodies which can be detected by blood tests, and by which the presence of HIV is inferred. Antibodies often appear within six weeks of infection and most experts agree that within six months of infection, 90% of HIV-infected people will have developed antibodies against the virus, although most do not show the acute symptoms of seropositivity.

Long dormant phase during which virus remains contagious.

Following infection, most HIV-infected people remain without apparent symptoms for varying lengths of time. Yet they remain capable of transmitting HIV to others. This dormant phase usually lasts at least two years, and in some cases, it may take as long as seven years or more for new symptoms to appear.

From the point of view of disease control, the length of this dormant but infectious phase is one of the most important aspects of HIV infection. It means that many people may remain unaware for years that they are infected and may not take appropriate precautions to prevent further transmission. Since most estimates of the number of HIV-infected people are derived from the number of those who actually develop AIDS, these estimates lag years behind the actual spread of the virus. As a consequence, we have only limited data on the current spread of HIV infection, both worldwide and here in Nova Scotia.

Unclear whether all infected persons will develop AIDS.

It is not yet clear whether all persons who are infected with HIV will eventually develop further symptoms, or whether for some, the virus will remain dormant for the duration of their natural lives. Researchers, however, generally believe that the risk continues for life, and many believe that everyone who is infected will eventually develop AIDS. Current data indicate that approximately 35% of those infected with HIV will develop AIDS within five to seven years following infection.

What prompts the dormant viruses to begin attacking the immune or central nervous systems is one of the key unanswered questions about AIDS. Some scientists believe there must be additional factors which trigger the destructive action of the virus.

When symptoms do appear at the end of the dormant phase, they can take a variety of forms of varying severity.

Some HIV-infected people with no other symptoms suffer a generalized swelling of the lymph glands which persists over time.

Others suffer from a collection of mild to moderate symptoms such as swollen lymph glands, persistent night sweats, diarrhea, severe tiring and loss of weight. These symptoms were previously described as "AIDS-Related Complex."

Neurological symptoms.

When the virus attacks cells of the central nervous system, it causes a variety of neurological symptoms. These may include mood changes, diminished concentration and problems with short-term memory. It should be noted that there have been no recorded cases in which

neurological symptoms have led to the transmission of HIV through irrational or irresponsible behavior.

Finally, when the virus has sufficiently impaired the immune system, HIV-infected people start falling prey to one or more opportunistic infections or cancers. This is the stage which is actually described as AIDS. The illnesses most commonly associated with AIDS are Pneumocystis carinii pneumonia (PCP), a previously-rare form of pneumonia, and Kaposi's sarcoma (KS), a previously-rare cancer.

AIDS typified by repeated episodes of acute illness.

Vulnerable to many infectious organisms in their environment, they face the terrible "roller-coaster" of AIDS for the duration of their lives: the alternation of periods of relative wellness with repeated episodes of acute illness, one of which will finally prove fatal.

Although people with AIDS currently have a markedly shortened life expectancy, some may respond well to specific treatments. In the course of their illness, people with AIDS require a wide variety of care – in hospitals, in out-patient clinics, in residential settings, in long-term care facilities and in their own homes. Also, they may require financial assistance even during periods in which they are apparently healthy. Adapting to the pattern of long-term but intermittent illness associated with AIDS is itself a challenge to the health care and the social service systems.

Modes of Transmission

HIV is not easily transmitted.

Because AIDS is so highly-publicized and is endemic in some parts of the world, many people assume the virus must be highly-contagious. Fortunately that is not the case: HIV is not easy to transmit.

HIV is a fragile virus which does not survive easily or long outside the body. It is not borne by air. HIV is transmitted only through certain body fluids and for transmission to occur:

- a body fluid containing a high concentration of the virus must exit the body of an infected person;
- that body fluid must enter the bloodstream of an uninfected person in sufficient quantity to cause infection.

HIV transmitted only through certain body fluids.

Among all cases of AIDS worldwide, only blood, semen, vaginal secretions, and possibly breast milk have been implicated in HIV transmission. While traces of the virus have been isolated in other body fluids, such as tears and saliva, there has been no recorded case of transmission through these fluids, probably because the virus is not found in these fluids in sufficient concentration to cause infection.

Some people demand absolute certainty that HIV cannot be spread through everyday contact with infected people. It is, of course, scientifically impossible to prove that a particular event cannot occur, but by any

practical definition, it is now certain that HIV cannot be transmitted by everyday contact with an infected person.

No cases of transmission through casual contact among family members.

The best evidence on the absence of risk from everyday contact with HIV-infected people is derived from studies of their family members. In seven studies, a total of 491 family members of 228 AIDS patients were carefully followed up. These studies have failed to find a single case of HIV infection among household members who did not have additional exposure through one of the recognized modes of transmission. These family members shared all household facilities, including items likely to be soiled by the infected person's body fluids. Personal interactions, such as hugging and kissing on the lips, took place with great frequency. Despite this close exposure over prolonged periods, none of the household members became infected.

Among 111,854 reported AIDS cases, no evidence of transmission through day-to-day contact.

In fact, among the estimated five to ten million HIV-infected persons worldwide, including the 111,854 reported cases of AIDS, and the inestimable number of contacts with uninfected people, there has not been a single known case of HIV transmission through everyday contact with an infected person. Specifically, there have been no recorded cases of HIV being transmitted:

- through casual contact with people or objects;
- from sharing food, kitchenware, swimming pools, water fountains or toilets;
- through kissing, hugging or shaking hands;
- through bites from mosquitoes or other insects;
- through saliva, tears or feces;
- through everyday contact among family members;
- through everyday contact with a co-worker;
- through food preparation or handling.

There is no reason to fear sharing a meal, an apartment, a classroom, a washroom or a workplace with an HIV-infected person. Such fears are an understandable but unfortunate distraction from the ways in which HIV is actually transmitted.

Four primary modes of transmission.

HIV infection has been narrowed down to four primary modes of transmission:

- through sexual contact with an infected person, by far the most common mode of transmission;
- through the sharing of contaminated needles or syringes among intravenous drug abusers;
- through the transfusion of infected blood or blood products or through the donation of organs or sperm by infected persons, a mode of transmission which is now effectively controlled;
- from an infected mother to her child in the uterus or at birth.

Some people have constructed elaborate scenarios by which HIV might be transmitted outside these four modes through accidents. Given that a quantity of infected blood must enter the bloodstream of an uninfected person for transmission to occur, the risk of HIV infection through an accident in everyday life is a virtual impossibility. The risk of accidental transmission of HIV is generally limited to the health care setting, where blood and body fluids are frequently handled and the use of sharp instruments is common. Even then, when accidents have occurred in which infected blood or body fluids have entered the bloodstreams of health care workers the proportion of those who have become infected with HIV as a result is probably less than 1%.

Cases in which no cause of infection was identified do not support transmission through everyday contact.

In 3% of reported AIDS cases, a definite cause of infection was not identified, generally because the subject refused to co-operate or died before the case was investigated. A study in the United States of cases in which no risk factor could be identified showed that 40% of these infected persons had a history of other sexually-transmitted diseases, suggesting that sexual transmission may have been involved in many of these cases. The percentage of cases in which a risk factor was not identified does not support transmission through everyday contact with infected persons.

Sexual Contact

HIV primarily sexually-transmitted.

HIV is primarily sexually-transmitted. Both worldwide and in Canada, sexual transmission is involved in the vast majority of cases of HIV infection. In Canada, sexual transmission is implicated in almost 90% of AIDS cases.

HIV can be transmitted sexually between men, from men to women and from women to men, although the frequency of female-to-male transmission appears to be lowest. HIV infection is most consistently linked to anal and vaginal intercourse without the use of a condom. There have been no recorded cases to date of HIV transmission solely attributable to female-to-female sexual contact.

Risks of sexual transmission vary.

We do not yet know the risk of acquiring HIV infection from a single or several sexual encounters with an infected person. There are individuals, both heterosexual and homosexual, who have had repeated sexual relations with HIV-infected people without becoming infected. There are others who became infected after only one sexual encounter. In various studies, the infection rate among the regular heterosexual partners of infected persons has ranged from 7% to 68%. In general, available information indicates that HIV is less easily transmitted than diseases such as syphilis and gonorrhea, which carry substantial risk from a single exposure.

It is not yet clear whether some individuals are intrinsically more able to resist HIV infection or some infected individuals are less capable of transmission. The presence of other sexually-transmitted diseases may increase the risk of HIV transmission through damage to tissues.

While we do not know the exact risks involved, we do know that certain types of sexual behavior carry higher risks than others. This information must be the basis of disease control through public education on safer sexual practices. There is general agreement that:

Safer sexual relations key to prevention.

- There is risk in sexual activities which involve the exchange of semen, vaginal secretions or blood.
- There is a high risk in any sexual activity which traumatizes tissue, and receptive anal intercourse carries the highest risk.
- Risk is higher with sexual partners who have themselves engaged in high-risk activities, such as anal intercourse or the sharing of intravenous needles.
- As the number of sexual partners increases, so does the risk that one of them will be infected with the virus.
- Risk may be reduced by the proper use of condoms.
- There is no risk in celibacy or a mutually monogamous relationship between two uninfected people.

Heterosexual relations probably leading route of transmission worldwide.

AIDS cases to date have indicated that in North America, HIV infection through sexual transmission has been primarily linked to homosexual activity. However, heterosexual activity is probably the leading route of HIV infection worldwide. Some projections suggest that by 1991, heterosexual transmission may account for 5% of adult AIDS cases in the United States.

Sexual orientation per se not a risk factor.

It is important when discussing sexual transmission of HIV to draw a distinction between "high-risk groups" and "high-risk behaviors." The latter term more accurately describes the risk of HIV infection. For instance, an uninfected homosexual man might be described as belonging to a "high-risk group"; yet if he were engaged in a long-term mutually monogamous relationship with another uninfected man, he would be at no more risk than a heterosexual in a similar relationship. Sexual orientation *per se* is not a risk factor.

Contaminated Needles and Syringes

The sharing of needles is a common practice in some places among abusers of intravenous drugs. Since blood is withdrawn into the needle before injection of the drug, it would be hard to design a better system for the transmission of a blood-borne virus. Often, small quantities of the drug are injected repeatedly, with intervening withdrawals of blood.

Contaminated needles an important mode of transmission in the United States and Europe.

Intravenous drug abuse has had an important role in the transmission of HIV in the United States and Europe. In the United States, 25% of AIDS cases are among those for whom intravenous drug abuse is the only risk factor. Intravenous drug abusers represent the largest pool of HIV-infected heterosexuals in both the United States and Europe, and the largest pool of HIV-infected women of child-bearing age.

As of July 25, 1988, there were 13 cases of AIDS resulting from intravenous drug abuse reported in Canada, representing only 0.6% of total cases. However, the Royal Society of Canada estimates that there are 10,000 intravenous drug abusers in Canada, and it is feared that the sharing of contaminated needles and syringes among them may yet become an important mode of HIV transmission in Canada.

Transfusion of Blood and Blood Products; Donated Sperm and Organs

Never any risk to blood donors.

Because a new, sterilized needle is used for every donation, there is no risk whatsoever of HIV infection to anyone donating blood, nor has there ever been. HIV transmission has in the past taken place through the transfusion of blood and blood products donated by infected persons. If transfused blood or blood products are infected with HIV, the risk of transmission is almost 9 out of 10.

Transmission through transfusion and tissue donation now effectively controlled.

Since November, 1985, the Canadian Red Cross has been testing all donated blood for the presence of HIV antibodies. In addition, the Red Cross has instituted a system of self-deferral to allow persons who have engaged in high-risk activities to refrain from donating blood. Those who are asked not to donate blood include:

- anyone who has AIDS or has tested positive for the HIV antibody;
- anyone who has shared a needle or used intravenous drugs;
- any man who has had sex with another man since 1977,
- anyone who has had sex with someone, other than their usual partner, who is from somewhere where AIDS is common, for example, Sub-Saharan Africa, Haiti or major American cities;
- anyone who has regularly received blood products;
- anyone who has had sex with partners in any of the above categories, or with partners, including prostitutes, whose sexual habits are unknown to them.

The risk of HIV infection to a recipient of a unit of blood is now extremely low and, since 1985, no transfusion-associated case of HIV infection has been found among recipients of blood which has been tested for the HIV antibody. Additional cases of AIDS are expected among those who received transfusions before November, 1985.

Blood products such as proteins and clotting factors have in the past been of particular concern because they are derived from whole blood taken from many sources. The risk of HIV transmission through the transfusion of blood products is now controlled through the use of heat in the manufacturing process.

The risk of HIV infection through donated organs or sperm is generally controlled through systems of testing and self-deferral of donors similar to those used for blood donations. Recent reports of possible infection

through heart transplant surgery in Toronto underline that the risk continues when testing cannot be carried out.

From an Infected Mother to Child

High risk of transmission from infected mother to child before or during birth.

HIV may be transmitted from a infected mother to the fetus through maternal circulation or to the infant during birth. The risk of transmission from infected mother to child in one of these ways is estimated to be 50%.

Infection after birth through breast-feeding has been described only in several cases in which the mother became infected after the birth of the child, but breast-feeding is not recommended for mothers who become infected with HIV either before or after the birth of a child.

Occupational Risk of Infection

Low occupational risk of HIV transmission.

The work of health care providers and those in a few other professions puts them at risk from a number of different infections. However, the occupational risk of HIV infection is low.

As defined by the Centers for Disease Control, there are three types of accidents through which health care workers may face the possibility of infection with HIV or other viruses such as Hepatitis B which are borne by blood or body fluids. These are accidents through which infected blood or body fluids may enter the bloodstream:

- parenteral – through needlesticks and cuts;
- mucous membrane – through splash to eye or mouth;
- percutaneous – through exposure to large amounts of blood or body fluids or prolonged contact with blood or body fluids when the exposed skin is chapped, abraded or afflicted with dermatitis.

There have been several on-going studies of cases in which HIV-infected blood or body fluids have entered the bloodstreams of health care workers in one of these ways. These studies indicate that the infection rate is probably less than 1% from accidents in which HIV-infected blood or body fluids have accidently entered bloodstreams of health care workers. This is less than one-thirtieth the rate of Hepatitis B infection after similar accidents.

4. AIDS Worldwide

AIDS epidemic catches the world by surprise.

The history of AIDS is the history of an epidemic which built slowly and silently over a period of decades, then burst on the world in the 1980's with a shocking abruptness.

Looking back, we find the earliest evidence of HIV in African blood samples which were stored in 1959. Yet it was another twenty-two years before the syndrome was medically defined.

The first published description of the Acquired Immune Deficiency Syndrome appeared on June 5, 1981. Seven years later, the World Health Organization estimates a total of 250,000-300,000 cases of AIDS in 140 countries and territories.

The Human Immunodeficiency Virus was first recognized as the cause of AIDS on May 20, 1983. Today it is estimated that five to ten million people are infected with the virus, including one to two million Americans.

By 1991, there could be a million new cases of AIDS among people already infected with HIV. AIDS is a worldwide concern; in some countries and among some communities, it is already a catastrophe.

History of an Epidemic

1976 A Danish woman surgeon working in northern Zaire dies of Pneumocystis carinii pneumonia (PCP). Retrospectively, perhaps the first known case of AIDS.

1978 A retrospectively-estimated 2% of homosexual men in San Francisco are infected by HIV. People from central Africa and the Caribbean appear in European hospitals with rare infections. The first case of AIDS in Canada, retrospectively-diagnosed.

Unexplained illnesses begin appearing among homosexual men.

1979 PCP and Kaposi's sarcoma (KS) first noted in homosexual men in San Francisco and New York. First case of AIDS in Canada, retrospectively-diagnosed.

1980 Substantial numbers of cases of PCP, KS and other opportunistic infections appear in homosexual men in San Francisco, New York and Los Angeles. First references in gay press to rumors of new illnesses among homosexual men. Forty-three cases of PCP and KS reported to Centers for Disease Control (CDC) in the United States. Many cases go unreported. Four cases of AIDS in Canada, retrospectively-diagnosed.

AIDS first described.

1981 271 cases of AIDS reported in US; 6 in Canada; 359 worldwide. (It is important to note that, because of incomplete reporting from many countries, worldwide statistics consistently underestimate the actual total of cases and overestimate within that total the proportion of cases in the United States, where reporting is considered to be complete.)

June First published description of AIDS.

AIDS discovered in new populations.

1982 1,023 new cases of AIDS reported in US, 22 in Canada, 1,128 worldwide.

June — CDC reports AIDS among heterosexual drug abusers

July — CDC reports AIDS among hemophiliacs

December — CDC reports AIDS among people receiving blood transfusions.

1983 2,841 new cases of AIDS reported in US, 54 in Canada, including the first case diagnosed in Nova Scotia, 3,415 worldwide.

January — CDC reports AIDS among female sexual partners of men with AIDS.

Cause of AIDS discovered.

May — French team reports that a human retrovirus, which it calls Lymphadenopathy-Associated Virus (LAV), is the cause of AIDS.

1984 5,751 new cases of AIDS reported in US, 147 in Canada, 2 in Nova Scotia; 6,915 worldwide. The development of practical, reliable tests for the presence of the HIV antibody.

May — American team reports that human T-cell leukemia virus is the cause of AIDS. This is later established to be identical with LAV and is officially called "Human Immunodeficiency Virus" (HIV)

1985 10,227 new cases of AIDS reported in US; 328 in Canada; 3 in Nova Scotia; 12,694 worldwide. Canadian Red Cross begins screening donated blood for presence of HIV. Discovery of HIV-2.

First International AIDS Conference.

April — First International AIDS Conference meets in Atlanta, Georgia.

October — Actor Rock Hudson dies of AIDS, greatly increasing public awareness of the syndrome.

1986 15,823 new cases of AIDS reported in US; 492 in Canada; 6 in Nova Scotia; 21,932 worldwide. World Health Organization approves Special Program on AIDS.

June — Second International AIDS Conference meets in Paris. World Health Organization estimates 50,000 cases of AIDS in eight central African countries.

First possible treatment for some symptoms.

September — Announcement in US that azidothymidine (AZT) appears to be an effective treatment for alleviating the symptoms of some people with AIDS.

1987 19,904 new cases of AIDS reported in US; 669 in Canada; 15 in Nova Scotia; 28,949 worldwide.

	June	Third International AIDS Conference meets in Washington D.C.
1988	June	Fourth International AIDS Conference meets in Stockholm.

As of August 31, 1988, a total of 111,854 cases of AIDS worldwide had been reported to the World Health Organization. Of that total, 71,171 cases had occurred in the United States. The World Health Organization estimates there have in fact been 250,000 to 300,000 cases of AIDS worldwide since the beginning of the epidemic.

The large number of AIDS cases currently appearing is probably the result of infection early in the epidemic. Because of the time-lag between infection and the development of AIDS and reporting problems in many countries, it is difficult to predict the future course of the epidemic worldwide. Behavioral changes or the spread of the virus into new populations will only be reflected after the fact in a decrease or increase in the number of AIDS cases.

Extent of epidemic can only be estimated.

It can only be estimated how many people are at this moment infected with HIV, what percentage will actually develop AIDS and at what rate the virus is spreading. The World Health Organization estimates that there are five to ten million people worldwide who are infected with HIV. If 30% develop AIDS within five years of infection, we can expect 1,500,000 to 3,000,000 additional cases of AIDS worldwide by 1993 among people already infected with the virus.

Appearance of HIV-2.

In 1985, researchers in Africa isolated a second Human Immunodeficiency Virus, labelled HIV-2. HIV-2 appears to spread in the same ways and at the same rate as HIV-1, and requires the same measures of control. While very few cases of infection with HIV-2 have been diagnosed outside Africa, there seems little doubt that HIV-2 will spread to other geographic areas. The simultaneous occurrence of HIV-1 and HIV-2 will have implications for blood donor screening programs and vaccine development. In this report, the term "HIV" refers to HIV-1.

Patterns of Transmission

Different demographic groups affected in different parts of the world.

Worldwide, there is no single pattern of HIV infection. While four principal modes of transmission are universally recognized, their relative importance differs from country to country, and HIV infection has affected different demographic groups in different parts of the world. It is possible to discern three broad patterns of infection worldwide.

Pattern One

In North America, Western Europe, Australia, New Zealand and some parts of South America, HIV has been transmitted primarily through

In Pattern One, HIV transmitted primarily through homosexual relations and intravenous drug abuse.

homosexual and bisexual intercourse and through intravenous drug abuse. The male-to-female ratio of AIDS cases is ten to one or greater. Among gay communities, AIDS has been a tragedy. Sixty-five per cent of the total cases in the United States and 59% in Western Europe have been among homosexual and bisexual men. In some urban areas, more than half of homosexual men may be HIV-infected.

Heterosexual transmission growing but still limited.

The rate of infection among the general population in Pattern One countries is believed to be relatively low. A major outbreak of HIV infection among heterosexuals is not expected for the next few years at least. Heterosexual transmission and transmission from mother to child have been limited but are increasing.

In the United States, the proportion of AIDS cases in which heterosexual transmission was the exclusive risk factor has risen from 1% in 1983 to 4% by 1988, and in Canada, from 2.1% in 1985 to 2.7% in 1988. Most cases of heterosexual transmission have been among women, and most of these among sexual partners of intravenous drug abusers and, to a lesser extent, bisexual men. It is important to note that in cities such as San Francisco, New York, Los Angeles and Vancouver, where there has been a high prevalence of HIV infection within homosexual communities for a number of years, there has not yet been a substantial outbreak of HIV infection among heterosexuals who were not intravenous drug abusers or the sexual partners of intravenous drug abusers.

Transmission from mother to child is common only in areas with high concentrations of intravenous drug users, such as New York City. A high rate of HIV infection among prostitutes may be found in areas where a significant proportion of prostitutes are abusers of intravenous drugs.

Within this pattern, the percentage of AIDS cases represented by intravenous drug abusers varies from country to country, from 0.7% in Canada to 25% in the United States and 64% in Italy. Transmission through blood transfusion occurred between the late 1970's and 1985 but has now been controlled through the testing of blood supplies and the self-deferral of those who have engaged in high-risk activities.

Growth rate of new cases declining in some Pattern One countries.

The rate of increase in new AIDS cases in some Pattern One countries, including the United States and Canada, has recently begun to decline. If the virus does not substantially spread into new populations, it is possible that this decline will continue. If so, it may be attributable in large part to the great effort in gay communities to control the spread of the virus through safer sexual practices.

Pattern Two

In Pattern Two, heterosexual relations primary mode of transmission.

In some African countries, Haiti and parts of South America, the primary mode of transmission has been through heterosexual intercourse, and the male-to-female ratio of AIDS cases is one to one. Infection through homosexual intercourse and intravenous drug use are uncommon. Blood transfusion and the medical use of unsterile needles and syringes may

also be important modes of transmission. The rate of transmission through heterosexual intercourse is substantially higher in Pattern Two countries than in Pattern One countries. Many researchers believe that there are co-factors which increase the risk of heterosexual transmission in Pattern Two countries.

High rate of infection in some regions of Africa.

In some regions of Africa, the rate of HIV infection among the general population is thought to be 5% to 15%, more than one hundred times the estimate for Canada. In some urban areas, up to 25% of those 20 to 40 years old may be infected, and up to 90% of prostitutes. Since in this pattern as many women as men are affected, transmission from mother to child is common. The large number of AIDS cases among the young, educated, urban middle class and among the newborn may threaten the socio-economic fabric of some developing nations.

Pattern Three

In Pattern Three, AIDS still rare.

In Asia, the Middle East, Eastern Europe and parts of South America, AIDS is still relatively rare. Both homosexual and heterosexual transmission are only now being recorded, and infection seems rare even among those with multiple partners. In Thailand, infection is now being recorded among intravenous drug abusers.

AIDS in Canada

AIDS in Canada falls within Pattern One.

AIDS and HIV infection in Canada fall within Pattern One. Homosexual/bisexual contact has been by far the most important risk factor. Transmission through the sharing of needles among intravenous drug abusers has been less significant than in some other Pattern One countries. The majority of AIDS cases have been among residents of the metropolitan areas of Vancouver, Montreal and Toronto. However, compared to initial cases of the syndrome, AIDS is now less concentrated in these three urban areas and less concentrated among homosexual and bisexual men.

As of August 31, 1988, the total number of AIDS cases reported in Canada since the appearance of the syndrome was 1,974. Of this total, 1,939 were among adults and 35 among children. Of adult cases, 1,839 were among men and 100 among women. To date, 1,078 Canadian adults have died of AIDS and 22 Canadian children. Canada has recorded 76.5 AIDS cases per 1,000,000 population, compared with 290.5 in the United States. The rate for Nova Scotia is 36.1 cases per million.

Classified by year of diagnosis, total AIDS cases in Canada break down as follows:

Year	Cases Diagnosed	Deaths to Date among these Cases
1979	1	1
1980	4	4
1981	6	6
1982	22	22
1983	54	51
1984	147	126
1985	328	271
1986	492	329
1987	669	255
1988 (to Aug.31)	252	36

Classified by risk factor, total adult AIDS cases in Canada break down as follows:

Homosexual/bisexual contact	1,594	82.2%
Heterosexual Contact:		
a. Origin in endemic area	95	4.9%
b. Sexual contact with persons at risk	48	2.5%
Recipient of blood/blood products (pre-1986)	89	4.6%
IV drug abuse	13	0.7%
Homosexual/bisexual contact and IV drug abuse	49	2.5%
No risk factor identified	51	2.6%

Classified by risk factor, total pediatric AIDS cases in Canada break down as follows:

Perinatal	30	85.7%
Recipient of blood products	5	14.3%

Classified by age groups, total adult cases in Canada break down as follows:

15-19 years	0.3%
20-29	20.1%
30-39	46.2%
40-49	22.7%
50+	10.6%

Extent of HIV infection in Canada can only be estimated.

There is no country in the world with reliable information on how many of its citizens are infected with HIV. There have been widely-quoted estimates of 75,000 to 100,000 infected Canadians, but any number is at best speculative. The Royal Society of Canada estimates that as of September, 1987, there were 30,000 HIV-infected people in Canada, but admits the number could be as low as 10,000 or as high as 50,000. The estimate of 30,000 HIV-infected Canadians would include 1,100 people who received blood transfusions prior to 1986, 1,600 people from endemic regions, 440-640 intravenous drug abusers, 600 heterosexual contacts of the above groups, at most 1,600 members of the general population and approximately 25,000 homosexual and bisexual men.

Mathematical models differ on the number of new cases of AIDS expected in Canada. The logistical model predicts a total of about 4,000 by 1991, with a rate of increase of about 600 cases a year. The polynomial model predicts about 7,000 cases by 1991, with a growth rate of about 1,800 cases in that year.

Growth in rate of new AIDS cases declining in Canada.

Until recently, the number of new cases of AIDS diagnosed in Canada has about doubled every year since the appearance of the syndrome. This is described as the exponential phase of an epidemic. However, although the number of new cases continues to grow, the growth in the rate of new cases has recently begun to decline. The Royal Society of Canada notes that there are several conclusions which can and cannot be drawn from this fact:

- It means that the growth in the number of AIDS patients is no longer exponential and the exponential model is no longer applicable to Canada.
- It means that the rate may be in a phase of decline as it proceeds toward a zero growth rate with a constant number of new patients every year.
- It does not mean that this plateau is close to being reached.
- It does not mean that if it is reached, this steady state will go on indefinitely.
- It does not mean the problem of AIDS will disappear, only that the stage in which the maximum number of new cases that will occur in Canada each year may have been reached.

AIDS in Nova Scotia

In Nova Scotia currently, all cases of HIV infection diagnosed in the province must be reported to the Department of Health and Fitness. Cases are recorded only in the province in which they are diagnosed in order to avoid double-counting at the national level.

32 AIDS cases so far diagnosed in Nova Scotia.

As of August 31, 1988, about 150 cases of HIV infection had been reported in Nova Scotia. Of those infected persons, 32 had developed AIDS. In addition, there were perhaps 10 persons with AIDS resident in Nova Scotia whose condition was diagnosed elsewhere.

Classified by risk factor, adult AIDS cases diagnosed in Nova Scotia generally follow the pattern for Canada as a whole. There is an even higher concentration – 90.3% – classified as arising from the category of homosexual/bisexual activity. There have been no reported cases of AIDS in Nova Scotia in which the risk factor was heterosexual intercourse, no cases among intravenous drug users and no cases of perinatal transmission. Among the 32 AIDS cases diagnosed in the province, there has been one case of pediatric AIDS; the risk factor was blood transfusion.

Classified by risk factor, the 31 adult AIDS cases diagnosed in Nova Scotia since 1983 break down as follows:

Homosexual/Bisexual contact	28 cases	90.3%
Transfusion of blood/blood products	2 cases	6.5%
No identified risk factor	1 case	3.2%
Heterosexual contact	0 cases	0.0%
Immigration from endemic area	0 cases	0.0%
IV drug abuse	0 cases	0.0%

Classified by year of diagnosis, total AIDS cases in Nova Scotia break down as follows:

Year	Cases Diagnosed
1983	1
1984	2
1985	3
1986	6
1987	15
1988 (to Aug.31)	5
Total:	32

In addition to the 32 AIDS cases, there have been 120 persons in Nova Scotia who are HIV-infected but have not yet developed AIDS. Of these 120 persons, 91 are noted as having contracted the virus through homosexual/bisexual contact. There are four persons who have contracted the virus through heterosexual activity – three from contact with a bisexual and one from contact with a recipient of an infected blood product.

The remaining 25 persons have contracted the virus as a result of the transfusion of infected blood or blood products. These people were all infected prior to November 1985. At that time, the Canadian Red Cross began the screening of blood supplies for the presence of HIV. Since then, there have been no reports of HIV infection resulting from a blood transfusion. The risk of transmission through the transfusion of blood products is now controlled by use of heat treatment in the manufacturing process.

Mathematical models cannot predict accurately the number of future AIDS cases.

Mathematical models can in some cases be used to predict the number of new AIDS cases to be expected in a given jurisdiction. However, there is a serious flaw in attempting to apply to a small province such as Nova Scotia models which use as their data base recorded AIDS cases to date. Models based on the small number of AIDS cases so far recorded in Nova Scotia necessarily have a margin of error that is too great to allow meaningful or useful predictions.

Task Force expects level of HIV infection to remain relatively low in Nova Scotia.

Barring an unexpected outbreak of HIV infection into new populations, it is expected that the the rate of new AIDS cases in Nova Scotia will peak within three to five years. The figures as of August 31, 1988, indicate the growth in the rate of new cases may already be declining. For instance, 26 new cases of HIV infection were diagnosed in the first six months of 1988, the same number diagnosed in the first six months of 1987. The Task

Force expects that HIV infection will remain at relatively low levels in Nova Scotia compared to some other places.

At the same time, we must note that Nova Scotia ranks fifth among Canadian provinces in the total of AIDS cases per capita. We have only limited data on how and at what rate the virus is spreading, or even the extent to which it has spread in recent years. Cases of transmission through heterosexual intercourse and intravenous drug abuse have thus far not occurred in significant numbers in the province. But there will be cases of AIDS in Nova Scotia resulting from these modes of transmission. There is no reason to be complacent.

5. What Nova Scotians Think About AIDS

Nova Scotians' attitudes toward policies relating to HIV will have an important effect on the success of those policies. In addition, it is important to the design of AIDS education and information programs to determine how much Nova Scotians already know about HIV infection.

The Task Force learned a great deal about Nova Scotians' attitudes on AIDS from its series of public meetings held throughout the province. The formal submissions provided important input into the policies we have recommended. Questions and statements from the floor provided valuable insight into Nova Scotians' worries and opinions about AIDS.

Two opposing set of beliefs about AIDS.

It was possible during the meetings to delineate two opposing sets of beliefs about AIDS. One set of beliefs – representing most of the presentations and statements from the floor – was typified by trust in the medical understanding of HIV infection and a non-judgemental approach to those who are infected. Presentations reflecting this point of view emphasized the need for explicit information about how the virus is transmitted, the absence of risk in everyday contact with HIV-infected people, compassion without judgement toward those who are infected with HIV and the need to protect their rights.

A second set of beliefs – representing a significant minority of presentations and statements from the floor – was typified by a mistrust of medical authorities and a judgemental approach toward those whose high-risk behavior, particularly sexual behavior, had led to HIV infection. Presentations reflecting this point of view emphasized the need for education on sexual morality, a belief in the possibility of transmission through everyday contact with HIV-infected people and the possible need to restrict their rights.

Concern for the young.

Yet those who held these divergent points of view were brought together by their concern. For most, the concern was not personal, but concern for the young. Among the young people themselves who addressed the Task Force, there was a universal desire for the facts they will need to protect themselves and their future sexual partners against

HIV infection. Many stated that factual information about HIV transmission is not yet easily available to them.

In the course of these meetings, the Task Force received literally hundreds of policy suggestions on education and information, health care and legal and ethical issues. A list of the wide range of suggestions received is included in the background documentation to this report. Many of these suggestions are incorporated in the Task Force recommendations which follow in part II.

Survey on knowledge of AIDS and opinions on AIDS policies.

In addition to its public meetings, the Task Force commissioned a study of what Nova Scotians think and know about AIDS, based on questions posed to a representative sample of 600 Nova Scotians 18 years and older. This survey was intended to assist in the identification of requirements for educational and other programs. It was limited to adults so as not to duplicate the results of a federal study on the attitudes of young people, including young Nova Scotians.

The objectives of the study were:

- to examine perceptions of AIDS as a health threat;
- to assess whether the appearance of AIDS has significantly affected behaviors;
- to explore perceptions of policy options for treatment of people with AIDS and prevention of spread of the virus;
- to examine issues regarding AIDS and the school system;
- to identify sources of information about AIDS and assess satisfaction with their reliability.

Nova Scotians want both protection and fairness.

Nova Scotians believe that AIDS is a serious threat to health, the most important health issue facing the province. Yet the vast majority does not feel they are personally at risk, and most have changed their sexual behavior little or not at all. Nova Scotians give priority to protecting public health, but a large majority wants people who are HIV-infected to be treated fairly and without discrimination.

Most accept the current medical understanding of AIDS, but a significant minority does not.

Nova Scotians are relatively well-informed about AIDS, although several misconceptions stand out, and they generally believe the prevalent scientific opinion concerning the limited number of ways in which the virus can be transmitted. However, there is a significant minority – perhaps 30% – who do not necessarily believe what the medical profession tells them about the transmission of HIV. They fear transmission of the virus through casual contact with a person who is HIV-infected, and as a consequence, they are more likely to support mandatory testing, quarantine and public disclosure of HIV status, and they would be more likely to withdraw their children from school if an HIV-infected teacher or student were present.

Nova Scotians say AIDS is the number one health issue.

Almost half of Nova Scotians – 46% – believe that AIDS is the most important health issue facing the province. No other health problem is perceived to be as pressing. This response is particularly striking because

it was given without prompting to the open-ended question, "What is the most important health issue facing people in Nova Scotia today?" AIDS is perceived by all age groups as the most important health issue. It should be noted, however, that this survey was undertaken as the Task Force was holding its public meetings. This may have resulted in a heightened public awareness of the issue of AIDS at that particular time.

Almost nine out of ten Nova Scotians feels AIDS is a serious threat to health. Women tend to consider AIDS a more serious threat than do men, and people who are not married rate it more seriously than those who are.

Most do not feel they are personally at risk.

The majority of Nova Scotians believe that certain people are more at risk from AIDS than others, notably the homosexual community and to a lesser extent, heterosexuals with multiple sexual partners. For most, the likelihood of contracting AIDS themselves is perceived as extremely remote, and only 10% said the appearance of the syndrome might change their sexual behavior a great deal, most frequently by becoming more cautious in their choice of sexual partners.

Most Nova Scotians understand that HIV is transmitted primarily through sexual activity, and to a lesser extent, through blood transfusions and the sharing of infected needles. However, 47% per cent also said that HIV could be contracted through donating blood. This misconception, if uncorrected, could have serious implications for the blood donor program.

The majority of Nova Scotians – 70% – believe the statements of medical experts that HIV is not transmitted through everyday contact with an infected person. Nonetheless, 30% said they would be somewhat concerned if they themselves came into contact with someone who was known to be HIV-infected, and 21% said they would be very concerned. Twenty-nine per cent of respondents said they believed HIV could be contracted through children playing with a child who is infected, 22% through eating food prepared by someone who is infected, and 12% through sharing office equipment with someone who is infected.

Most Nova Scotians do not support discrimination against infected persons.

While most Nova Scotians view AIDS as a serious threat, and do associate the syndrome with the male homosexual community, they want protection in the context of fairness. They do not want people who are HIV-infected discriminated against or people with AIDS treated differently from other patients within the health care system.

Eighty-one per cent said that if proper infection control procedures are followed, HIV-infected people do not pose a threat to public health. Eighteen per cent of Nova Scotians said people who are HIV-infected should be separated from the general population. Sixty-five per cent said HIV tests should be voluntary, and 18% said results should be made public. Most believed that positive results should be reported to the Department of Health and Fitness, but 58% said they were not confident that if reported, names would remain confidential. Support for contact tracing was almost universal.

HIV infection in the workplace.

About one-third of respondents said they would be concerned about contracting HIV at work. Most said the protection of uninfected employees takes precedence over the interests of an infected employee, but 75% said an employer should not have the right to fire someone who was HIV-infected. At the same time, 68% said workers should be informed if a co-worker were HIV-infected, and 50% said employers should have the right to require an HIV antibody test before hiring someone.

Similarly, 78% of Nova Scotians do not believe a landlord should have the right to refuse to rent to someone who is HIV-infected, and 60% believe other tenants do not have a right to know. Thirteen per cent said they would move out of a building rather than share it with someone who is infected. Forty-one per cent said they would stay in the building but would not share common facilities such as laundries.

HIV-infected persons in the educational system.

The presence in schools of teachers or students who are HIV-infected has throughout North America been one of the most contentious issues revolving around AIDS. In this survey, Nova Scotians were asked whether they would send their children to school with someone who was HIV-infected with confidence, with misgivings, or not all. The answers indicate that while the problem is difficult, it is not intractable.

The responses varied according to how the infection had been contracted, and whether the HIV-infected person was a male teacher, a female teacher, a male teacher who was a homosexual, or a student. Depending on the category, 30% to 40% would send their children to school with confidence; another 35% to 45% would send their children to school with misgivings, and 15% to 29% would not send their children to school at all.

Nova Scotians were also asked whether they would send their own child to school if he or she were HIV-infected. Sixty-seven per cent said they would continue to send their child to school, and 59% said they would expect other parents to continue sending their children to the same school as the infected child.

Overwhelming support for AIDS education in the schools.

There is overwhelming support in Nova Scotia for AIDS education in the public schools. Ninety per cent said such programs should be mandatory. Fifty-two per cent said AIDS education should begin in junior high school and 40% said it should begin in elementary school.

Nova Scotians get most of their information about AIDS from television, newspapers and radio. Television is believed to be the most reliable source of information. However, Nova Scotians would prefer to get more information about AIDS from the medical profession.

Media coverage may not fairly reflect opinions on AIDS.

The results of this survey indicate that in general, Nova Scotians are very concerned about AIDS, but want the problem addressed in an atmosphere of fairness toward those who are infected. These results are consistent with the views expressed by the majority of people who addressed the public meetings held by the Task Force.

6. Living With AIDS

Nova Scotians are suffering and dying of AIDS.

A report to government on the issue of AIDS must analyze the clinical, epidemiological, social and economic aspects of HIV infection. Yet, no matter how astute, such analysis is not enough. To produce policies which are wise and compassionate, we must also understand the human point of view, the simple fact that fellow Nova Scotians are suffering and dying from AIDS.

In its study of the issue of AIDS, the Task Force has come to understand how HIV infection has affected the lives of some Nova Scotians. In this section of the report, we would like to share with others what we have learned.

The personal stories which follow are three examples among many of what it means to live with HIV infection. The first is the story of an elderly woman who became infected through a blood transfusion. Severely handicapped with arthritis, she has been refused the care in a nursing home which she needs. The second story is of a member of the Task Force, infected with the virus but without symptoms, who was driven from his job and rejected by many in the community in which he was born and worked. The final story is of a man who has had AIDS for four years. He has struggled with a series of acute illnesses, each of which brings him closer to death.

Others' attitudes add to the suffering.

Sadly, these stories show that the negative attitudes of friends, neighbours, strangers—and even those with responsibility to provide care—cause a large part of the suffering endured by people who are infected with HIV. These stories also demonstrate the problems which arise when society is unprepared to deal with HIV infection and the reactions to it.

A Daughter's Story

My mother is seventy-eight. My father ran a lumber mill and my mother took care of the company books. She had boarders and took care of all her children. I don't remember that she ever had a lazy day in her life.

My mom's always had extremely bad arthritis. The medications are very hard on the stomach, and in February of '85, she was rushed to the hospital in Truro with a perforated ulcer. She was given quite a lot of blood, which saved her life.

We brought my mom to live in Halifax with us, and in April of '86, she had knee replacement surgery at the Victoria General. We had arranged that she would go into a long-term care facility afterward.

"Did you know your mother got bad blood?"

But two weeks after the operation, I got a telephone call. The hospital said, "Did you know your mother got bad blood in Truro?" I didn't understand. The person said, "She's contracted the AIDS virus. She's a

carrier. Are you sure you didn't know?" I was very upset. I telephoned our family doctor in Truro and he had known about it. I guess he figured she wasn't one of the people who would infect anybody, so he didn't tell us.

"...everyone was awfully glad to get rid of her."

The next morning I went to the hospital to bring my mother home. The people at the hospital seemed very angry, because they hadn't known to take any precautions. We felt like we had done something wrong, although we hadn't, and we were treated that way. I guess they felt that as a nurse, I should have known. I just felt everybody was awfully glad to get rid of her.

I wasn't given any instruction about my mother's condition and there was no follow-up. Luckily, the VON had picked up her chart and they called. I went in and they gave me the name of a doctor who treats AIDS patients. He's been absolutely excellent. I don't know what I would have done without that call.

My mom's been with us ever since. When she's sick with the arthritis, she requires full-time care. My husband and I haven't had a vacation together in three years. We don't do anything as a family. In terms of home care, I got tired of people not coming back after I told them about her condition. My husband was going to open a business in our home, but he couldn't.

"...it was suggested that we keep it quiet..."

My mother went through a very bad emotional time. I'm sure her reaction was one of shame. It's only now that she's getting over it. At that time, it was suggested that we keep it quiet, because people wouldn't accept it.

The best friends we have would never let us down. Nothing but support from them. But we've lost a lot of friends when we've told them. I had tea at someone's house, and I can bet that cup was broken after I left. That lady will have nothing more to do with me, and she doesn't want her children around my children. So when you get reactions like that, you're not going to tell people and make more problems for yourself. We didn't tell many people.

The minute I knew about her condition, I started working to get her into a long-term care facility, which I knew wasn't going to be easy. First, a social worker told me she had found a home that would take my mother. Then they changed their mind, and I lost six months thinking they were going to accept her.

Mom really wanted to go to Northwood Manor in Halifax. I went to see the director and the meeting seemed really good. We agreed that we'd take it slowly. They'd start their AIDS education program, and they'd accept her at some point.

"...he told me that I was being given the runaround."

I really believed in Northwood. They told me in September of '87 to send in the official application, but then they didn't ask for the monthly medical reports that are required, and by December, I was starting to

worry. I went to the doctor and he told me that I was being given the run-around. The application had never been filed.

In January, we arranged a meeting with Northwood. That was the most negative meeting I ever attended. I knew then that my mother would never get into Northwood. There were comments like, "Your mother can't even begin to pay what she's cost us." Remarks like that really hurt. They wouldn't even take her in one of their individual apartments.

"...the first good thing that's happened to us in two years."

My mother got very sick in February of this year with diarrhea. The only way we could handle it was to leave her in the hospital. She went to the ward where they specialize in AIDS patients, and that was probably the first good thing that's happened to us in two years. There, we were treated like human beings. There were no snide remarks, like in the rest of the hospital. There was nothing but kindness.

Then we decided to reapply to Northwood. We got the same run-around, so we decided to go public with my mother's story. I just felt some good might come out of it. Mind you, I never could have done it without the help and the credibility of the doctor.

The government made an offer to help my mother, but it wasn't satisfactory. All my mother would have got was a companion, changing every two days. She would have had to furnish and manage the apartment on her own, and she wasn't capable. She said, "If you really want to get rid of me, put me in there and that'll finish me." She was really upset.

"It was just trying to hide her away."

It was just trying to hide her away. All the government was trying to do was sweep it under the carpet, just like Eric Smith. That's not the answer. I think she just needs to go into a home like everybody else.

At least now we don't have to live with the threat of people finding out. My mom made us promise not to tell anybody, and I respected that, but we can live easier now with people knowing the situation. I'm not going to hide it anymore. You live with it alone for so long and it's not shared, it eats away at you.

"I don't think people mean to be unkind."

We haven't revealed her name, but everyone in her village knows now. There are people there who are very negative about AIDS but who are going to accept it because it's her. I find that when people know my mom, they really enjoy her, and the AIDS becomes secondary. But for people who don't know her, she's just something to fear. You would like to think that people would look beyond and consider the human being. I don't think people mean to be unkind. The fear is there. It doesn't make sense, but to them it's real.

"...you can't catch it by casual contact or I'd have it."

I don't have any fear of being infected. My biggest fear was that I cared for her for nine months when we didn't know she had it. She had nose bleeds. Because of the arthritis, she couldn't get out of a chair or go to the bathroom without help. I didn't use gloves or anything, and I always have

cuts on my hands because I do crafts. I had myself tested, and I was negative. So that has to show me that you can't catch it by casual contact, or I'd have it.

We've just told our children. All they knew before was that Nanny had a blood disease. They knew that if someone came in the house and Nanny fell down, they had to pass out gloves, and that nobody could touch Nanny's blood. Their attitude when we told them about the virus was, "She can't give it to us, so what's the big deal?" The children have no fear of it.

Eric Smith: Society Unprepared

I was born and raised on Cape Sable Island, and I guess I'm related to most of the people there. I went to teachers' college in Truro and then got a job teaching back on the island. I was one of the lucky 30 out of 180 graduates who got a teaching job.

"Most people knew I was gay and there didn't seem to be any reaction."

It took me awhile to be comfortable again on the island, mostly because I'm gay and most of the people on Cape Sable are very religious. But I taught for nine years. Most people knew I was gay, and there didn't seem to be any reaction. I got involved with the local Liberal Party, the Teachers' Union and the local Home and School Association. There were never any complaints to the school board.

At the beginning of my ninth year, I went into the hospital for day surgery. Without my knowledge, the surgeon included an HIV test in the routine blood work. About two weeks later, he called and said that I had tested positive.

"OK, you're going to die."

My first thought was, "OK, you're going to die." I just went blank for a few minutes, and then I started to regain my senses. I knew that I was reacting foolishly because I'd kept up on what was being written about AIDS and I knew that testing positive didn't in itself mean I was going to die. But that's something it takes awhile to talk yourself into.

Ten or fifteen minutes after the call, my younger sister came home, and without thinking about what I was doing, I told her. She started to cry, and at that moment I knew that for the sake of the family, I had to come to terms with it awfully quickly.

The first thing I asked the doctors about was whether I would pose a threat to anyone through everyday contact. At that time I was staying with my sister and her husband, and they had four pre-schoolers. The doctors told me there was no risk.

Over the next week, I told my other sisters and my parents. They were upset, because again, death was the first thing that came into their minds, but there were no criticisms or negative comments. They knew I was gay,

and they were following the news about AIDS, so they weren't afraid of casual contact or using the same dishes as I did or anything like that.

After a couple of weeks, I more or less filed the whole thing away in the back of my mind. I don't know whether that means I've come to grips with the possibility of an early death, or whether I'm just hiding it somewhere.

I got the call in September of '86, and I taught through until the first of June '87, when the community found out. The secretary in my family doctor's office told her daughter, who had a daughter who was going to start school in September. Apparently she was worried about her granddaughter coming in contact with me, although we would have been in schools five miles apart.

"It didn't take long for word to get passed around..."

It didn't take long for word to get passed around the local church, and a couple of days later I got a call from an aunt who'd heard the rumor. I knew I had to go to school the next morning and tell the administration before they heard it second-hand. I told the principal and the other staff and they were very supportive.

"The school had no idea what to do..."

A couple of days later, the superintendent started getting inquiries from parents. The school had no idea what to do because they had no examples to follow. They called other schools and they called the Department of Education and they couldn't get any help. The only thing they could suggest was that I take the rest of the term on sick leave. I felt there was no reason to do that because I wasn't sick, so I continued to teach until the end of June. The kids in my class had no problem with it. They asked me quite often how I was feeling, but otherwise there was no change.

"...for others it was something else to hit the school board with."

It was over the summer that the parents' movement developed. Originally, they didn't seem too interested in my case because they were already involved in a fight with the school board over school reorganization. Then after they lost to the school board in court in July, they went after me. For some it was because they were afraid of AIDS; for others it was something else to hit the school board with.

The parents got an audiotape and a video based on "The AIDS Cover-Up", a right-wing, fundamentalist book: AIDS is God's punishment for homosexuality, that sort of thing. That was where they got most of their information.

The government and the school seemed to want to keep as much distance from the issue as possible. Instead of going in and trying to calm peoples' fears by providing information, they allowed them to get a lot of misinformation. Once that happened, I don't think there was any way to overcome it.

"...the issue switched to 'lifestyle'."

The issue at first was fear, because of what the leaders were telling the parents about what could happen to their children. They seemed convinced that there were a lot of bloody scenes at school, which I never saw in nine years of teaching. Now I think a lot of people have started to

believe what the doctors have been telling them about transmission, and the issue was switched to "lifestyle." I was never surprised that people were upset about AIDS, but after I'd already taught for nine years, I didn't think they'd make an issue of being gay.

Some of it I take personally. I have a contract now with the Department of Education but I'm still officially employed by the school board. Even though the school board is being reimbursed, the parents want me fired. They're upset because I gave a talk at the University of New Brunswick where I talked about condoms. They say that shows I have no morals.

"...I don't think anyone has held it against my family."

On the other hand, there have been quite a few people who've got involved on my behalf, who've had the courage to speak up in public meetings. They've been people I barely knew, people who believed what the doctors were saying and not the parents' group. And I must say that I don't think anyone has held it against my family.

Of course, I'd rather the whole thing had never become public. It's not easy being a symbol. But I've met people who are infected with HIV and people with AIDS, and no matter how supportive your friends and family are, they can't really know what you're going through.

"...maybe I can accomplish something by going to talk to young people."

I miss teaching. Working on the Task Force and next for the Department of Education doesn't really satisfy me, although maybe I can accomplish something by going out to talk to young people. They want to know all there is to know about AIDS. They don't seem to have any problem with it.

I hope one thing that comes out of this mess is that if something similar happens, the people in charge will have some idea how to offset the reaction – to go in early and start their education programs.

One of the mistakes we make about AIDS education is that we talk about educating the general public and educating students, but we don't talk about educating leaders in government and business. We assume they've taken it upon themselves to be educated about AIDS, but they haven't, and as a result, they've been caught unprepared.

There is a successful American model we can follow in the schools, or in any workplace. When it's revealed there's an HIV-infected person in the school, the authorities ask the media to keep the issue quiet for a week or so. Then they hold a parents' meeting and begin to educate people. When they go in early and people learn the facts, there are very few problems.

Frank Morton: A Fighter

My name is Frank Morton. I'm from here in Nova Scotia, from the Annapolis Valley. I went to Acadia University and then I went to teachers' college, and I was a teacher for twenty years. I lived for many

years in Bedford with the man who was my lover. When he was transfered, I moved with him to Alberta.

"We sure as hell felt alone..."

He started to be ill around 1979. We didn't know it was AIDS for several years. We sure as hell felt alone, in a relatively strange city. And when it was discovered he had AIDS, about a third of our friends just disappeared, just like that. There was a core of people who were helpful, but there were no organizations in those days, and we pretty much had to do it on our own. But he just decided he would go on being the person he was as long as he could, and he did phenomenal things when he was ill. I really wonder where his strength came from.

In Alberta, I no longer taught. I looked after him. The things that I did seem almost menial, but now that I'm ill, I know how important they are. If he had a sweat, I'd change the bed, some nights three times. Little meals and all the household things. But he was always able to pull the rabbit out of the hat, and two months before he died, we spent a month in Hawaii and had a pretty good time.

"By September, I was ill."

He died in the spring of '84, and I came back here for the summer. By September, I was ill. The diagnosis was very difficult because there were no blood tests then. So although I wasn't feeling well for a long time, it was a nebulous kind of thing. The medical people I was seeing always leaned toward the opinion that, "Well, maybe you'll be lucky, maybe you won't have AIDS." I don't know if they really believed that, but I didn't believe it for a second. By then, things were being published about how you would contract AIDS, and I knew what my life had been. The shock would have been not to have it.

Nothing really happened to me until November, when about five major things all went wrong with me at once. I've never had Pneumocystis carinii pneumonia or Kaposi's sarcoma, but I've had other opportunistic infections. I've lost one of my bowels and I had a long period of encephalitis, of which I have no memory. That was in '84 and it dragged on through the winter of '85. It was terribly hard for my family, who kept being called in because I wasn't going to live. That happened about five times. I did live, and I had to go through the process of relearning how to walk, read, and talk.

"It's just a horrible, horrible thing."

It's been four years since then. They call it a roller-coaster when you have AIDS. Long periods of being terribly, terribly ill, being fed through a tube and all that, and then being able to come back. It's just a horrible, horrible thing.

My family is doing pretty well with it. I lived with my parents for about three years. My mother helped me and for medical things, the VON nurses came and they were wonderful. But it's terrible in the country where my parents live. Very discouraging. The worst experience was several times when I was walking, and a car would go by and it would slow down, and they'd be pointing at me and I knew they were all talking about me. It was very uncomfortable.

My mother's quite phenomenal. She's seventy-three. She had the experience of her sister having tuberculosis in the thirties, and how they were shunned, and she finds this very much like that. My parents have been dropped by some relatives, but at the same time, new, interesting, caring people have come into their lives.

"With AIDS, you're defenseless in many ways."

With AIDS, you're defenseless in many ways, medically and socially. There are people who've dropped me as a friend. On the other hand, I've met people who are just wonderful. So there's a replacement – more than a replacement. It's fear that makes some people drop away and some people come forward.

I moved to Halifax last Fall. I live by myself. This is a fairly good time for me, but I've just been in the hospital for three weeks. I found it very difficult this time. You get sick of hospitals after awhile. The care and the people are great, but after ten visits, it gets a bit distasteful.

I have quite a few support people. One of the things we need in this city is counselling or support services for caregivers. My sister has been my primary helper for over four years. That's a long time. She needs a break, but in lieu of that, perhaps she could talk to somebody who's doing the same thing.

"I just say who I am and let them speak, or cry if they wish."

I do miss working. Of course, there are days I couldn't think of working, but other days, I miss it so much. Because of having had the disease for four years, the place where I seem to be most useful is trying to help newly-diagnosed people. I'm often asked to visit people in the first ten days or two weeks. I don't do much. I just say who I am and let them speak, or cry if they wish.

There's a word "victim", and I don't want to be an AIDS victim. There really are AIDS victims. They let the disease take over. But you can make the choice between dying of AIDS and living with AIDS. You live with AIDS with great difficulty, but my choice has been to carry on as much as I can. There are organizations now, but it's not easier for me than it was for my lover. He had me but I don't have him, and no one can replace him.

There's a particular category of people with AIDS, those who've survived more than three years. We're very interesting to the scientists because they don't know how we've done it. But lots of tactics I've used my whole life that I was told to tone down – the assertiveness, the aggressiveness, the combativeness – those things have helped me wonderfully.

I am forty-nine years old. I *will* turn fifty in November.

II. Recommendations of the Nova Scotia Task Force on AIDS

1. Addressing the Challenge of AIDS

No magic formula.

In the absence of a cure or vaccine, there is no single solution or magic formula to address the multiple challenges posed by HIV. These challenges are unusual in their scope and depth. They are as much social as medical. They touch many facets of society and reach into the core of human relationships – into fear, rationality, responsibility, sexuality, compassion, community and concern for the young. No issue so broad and deep can be addressed quickly or simply.

Work has begun.

The work of addressing these challenges has already begun. The Government of Nova Scotia has initiated programs of AIDS education. Many school boards have already adopted programs of AIDS education and policies on the presence of HIV-infected persons in the schools. The Government has announced, in response to interim recommendations by the Task Force, educational programs for public schools and post-secondary institutions commencing in the Fall of 1988. Some hospitals in the province are providing excellent care to persons with HIV-related illnesses and two community groups are providing counselling and information. The social service system has provided support to persons who are in need as a result of HIV-related illnesses.

But many sectors remain unprepared.

But this is only a beginning. Adapting our society to the presence of HIV requires a detailed examination of its ramifications within many different sectors. It requires that Nova Scotians have an accurate understanding of how the virus is and is not spread and how its spread can be prevented. Although the public meetings of the Task Force demonstrated the willingness of Nova Scotians to address the problems associated with HIV, some sectors of Nova Scotia society remain unprepared to meet the challenge of controlling the spread of HIV and responding with fairness and sympathy to the needs of those who are infected.

The Nova Scotia Task Force on AIDS addresses that challenge in the 47 recommendations to government which follow.

No need to "reinvent the wheel".

In making its recommendations, there was no need for the Task Force to "re-invent the wheel." A great deal of research into AIDS has been done worldwide and an array of policies and programs has been implemented in other jurisdictions. The Task Force was able to examine many of these programs and determine which approaches would be most appropriate for Nova Scotia.

As noted in Part I, there is broad consensus on how democratic societies should properly respond to the appearance of HIV, a consensus with which the Task Force is in agreement. There are four principles on which this consensus is founded:

- preventing transmission of the virus is an individual responsibility to which society can contribute education and information;

- universal testing, mandatory testing and quarantine are not useful methods for controlling the spread of HIV;

- there is no public health need to restrict the rights of people who are infected with the virus or to make their condition public, except in very narrowly-defined circumstances;

- people who are infected with the virus have the same rights to compassion, health care and social services as other people.

These four principles are consistent with our response to Hepatitis B infection, which is transmitted by some of the same routes as HIV, is more contagious, more widespread and is also potentially fatal. These principles are also consistent with the kindness, concern and human rights which are fundamental to the fabric of Canadian and Nova Scotian society.

Three broad challenges.

Part I identified many specific challenges which must be addressed for Nova Scotia to deal successfully with the problems caused by the presence of HIV. These challenges fall into three broad categories:

- preventing further spread of the virus;

- ensuring appropriate and compassionate care for those who are infected;

- protecting the rights of those who are infected and ensuring that they can lead full and satisfying lives within the community.

Recommendations based on three principles.

These challenges correspond to the agenda followed by the Task Force, which divided its examination of the issues into the three areas of education, care, and legal/ethical considerations. The following overall conclusions emerged:

- *Education and information is the only significant way to limit further spread of the virus.* AIDS is a preventable disease, but it can only be prevented through responsible individual behavior. The vast majority of cases of HIV infection, in Nova Scotia as elsewhere, arise through sexual transmission. Nova Scotians must understand how to protect themselves and their sexual partners against the risk of HIV infection. Intravenous drug abusers must also be educated about the dangers of sharing needles.

  There is an immediate and long-term need for AIDS education and information for the general public, for the young and for those who may engage in high-risk behaviors. Programs of AIDS education and information must be consistent, accurate and easily-accessible and must be designed to affect changes in behavior. Education is

also the only long-term solution to prejudice, unwarranted fears and mistrust.

- *Safe and appropriate care and support can and should be provided within the existing health care and social service systems to persons who are HIV-infected.* There is no need at this time for special institutions or special facilities within institutions to treat persons who are HIV-infected. When proper infection control procedures are followed – procedures which were recommended long before the appearance of the virus – HIV-infected persons can and should be treated within an atmosphere of normality. Existing systems are capable of providing appropriate, safe and cost-effective care and support to persons who are HIV-infected.

  However, the health care, home care and social service systems must adapt further to the long-term but intermittent pattern of HIV-related illnesses. In addition, services for people who are HIV-infected are generally centralized in Halifax/Dartmouth and there is need for similar services in other regions. There is a requirement throughout the health care and social service systems for further training on infection control procedures and the needs of HIV-infected people.

- *Restricting the rights of HIV-infected persons is not justified.* There is no evidence whatsoever of HIV transmission through everyday contact between uninfected people and people who are infected with the virus. Universal testing, mandatory testing and quarantine would have great social cost and do little to control the spread of HIV.

  The Task Force believes that the overwhelming majority of HIV-infected persons are taking the necessary steps to prevent further transmission of the virus. There is no reason to deny them full rights to employment, housing and public services or to make their condition public. These rights must be guaranteed. Rare instances in which the activities of an HIV-infected person may have to be restricted should be dealt with on a case-by-case basis by competent public health authorities.

Three types of costs associated with HIV infection.

The Task Force was mindful throughout its deliberations of the direct costs to government of the recommendations it was considering. However, it was also mindful of the human and financial costs which HIV infection itself imposes on individuals and society.

Above all are the human costs of HIV infection: physical suffering, alienation from the community, premature death and the loss of loved ones.

Health care costs for a person with AIDS estimated at $82,000 per year.

In addition, there are the direct costs to government of HIV infection. These include the costs of prevention through programs of education and information and the costs of caring for those who suffer from HIV-related illnesses. The exact cost of caring for a person with AIDS is not yet known. The pattern of illness varies from patient to patient and patients

live for varying lengths of time. The Royal Society of Canada estimates that health care for a person with AIDS costs about $82,000 a year, which is consistent with the costs for other major illnesses. The Task Force expects that the costs of caring for persons with AIDS in Nova Scotia will remain a minor percentage of total health spending.

Indirect costs eight times direct costs.

Finally, there are the indirect costs of HIV infection through loss of productivity. These costs are estimated to be eight times the direct cost to government of programs related to HIV infection and have budgetary implications for government through loss of revenue. Productivity may be lost not simply through illness or death caused by HIV infection. It may be lost through disruption in the workplace because of the presence of a worker who is known to be HIV-infected, or when a worker who is HIV-infected loses or is unable to find employment because of discrimination.

Successful prevention saves all other costs.

Money spent on successful prevention saves all other costs. $82,000 spent on education and information will pay for itself if it prevents even one case of AIDS. It will save also the indirect costs of loss of productivity associated with a case of HIV infection. In human terms, the benefit of prevention is incalculable. An ounce of prevention is priceless when there is no cure.

For a number of reasons which are discussed in detail in an appendix to this report, cost information is not provided for individual recommendations. Among the reasons for this are:

- Certain recommendations involve programs whose extent, and thus cost, will be determined by government in light of competing claims on resources.

- Studies have not yet been done in Canada to determine the costs associated with most types of non-hospital care for persons with HIV-related illnesses, and for hospital costs, only estimates are available. One of the Task Force's recommendations addresses this issue.

- The number of future AIDS cases in Nova Scotia cannot at this time be estimated with complete confidence. One of the Task Force's recommendations addresses this issue.

Recommendations and priorities.

The Task Force was directed to make recommendations in order of priority. We have sought to consider all aspects of the matters we were directed to address but ranking recommendations in relation to their relative importance does not seem useful in light of our broad mandate. However, priorities in relation to the time for taking action on recommendations which are approved by government will be implicit from the recommendations themselves. Thus interim recommendations were made in April 1988, relating mainly to public information and education programming, in the expectation that if programs were to be implemented in schools and educational institutions in the Fall of 1988 decisions were required last Spring. For completeness, interim recommendations made last spring are included in this report.

Among recommendations now submitted for consideration are some which will require further consideration or preparatory work before implementation (for example, recommendations 15 and 39) or which would require legislation to be enacted by the House of Assembly. Some recommendations, if approved, will not require action because after consideration we are recommending continuation of existing policy and practice.

Many of the recommendations are for consideration by government alone, others would require cooperative action by institutions, and a few are commended to government but directed principally to non-government organizations and institutions. Thus the objectives of our recommendations will be met in a variety of ways, through cooperation of government and others and in varying time periods.

Recommendations cannot be taken in isolation.

The recommendations cannot be considered in isolation from each other; they are mutually reinforcing. For instance, controlling the spread of the virus will depend on an effective education program, on the development of a milieu that encourages voluntary testing by those whose activities may put them at risk and on the assurance that the rights of those known to be infected will be protected.

Also, these recommendations cannot be isolated from the national and international context: the fight against AIDS is a worldwide effort. For instance, programs of education and information must be consistent with information Nova Scotians are receiving through federal and American campaigns. Research must be carried out in the context of the national effort.

Finally, these recommendations cannot be isolated from the long-term nature of the problem. There is need for a body of government to co-ordinate the many facets of the fight against AIDS. The Task Force recommends that the Advisory Commission on AIDS perform this role. Nova Scotia will be facing the challenge of AIDS for many years.

2. AIDS Education and Information

Education is the only effective way to fight HIV transmission.

An effective, comprehensive program of AIDS education is at present the *only* significant means to prevent transmission of HIV. Currently, almost all cases of HIV transmission in Nova Scotia result from voluntary sexual behavior over which society has no direct control.

It is vital that through a co-operative public and private effort Nova Scotians understand the basic facts about AIDS, the modes of HIV transmission, and the risks associated with various behaviors. With this knowledge, people have the opportunity to protect themselves and others against infection through celibacy or the practice of safer sexual relations – through mutual monogamy, caution in the choice of sexual partners or the proper use of condoms. As well as addressing the risk of

sexual transmission, AIDS education must also address the risk to intravenous drug abusers of sharing needles.

Since HIV transmission now occurs almost exclusively through voluntary behaviors, it is said to be preventable. So, on the other hand, is lung cancer caused by smoking. Various "lifestyle" campaigns, such as those against smoking or drinking and driving, show that only through a concerted, long-term effort is it possible to effect successfully changes in behavior. To effect changes in sexual behavior – so sensitive, private and powerful – will be doubly difficult.

Education is not just passing out information.

It is clear that the successful promotion of "safer sex" will not be easy or quick. As the history of other such lifestyle campaigns makes clear, it will require more than "the facts." In that sense, there is a difference between information and education. Education is a long-term process which addresses social skills and deeply-held attitudes, as well as knowledge. Effective education on safer sex will have to address the right to be protected in a sexual relationship, the social skills to demand that protection and acquire the means, peer and social pressure and honesty in the discussion of sexual issues.

AIDS education must address prejudice and misconceptions.

AIDS education has another important purpose besides the prevention of HIV transmission. As the survey results indicate, some 30% of Nova Scotians continue to believe in the risk of HIV transmission through everyday contact with infected persons, despite the complete lack of evidence to support that belief. This leads to a host of attitudes toward people who are HIV-infected which are not based on fact. These attitudes strain the fabric of the community, cause unnecessary suffering for those who are infected and their loved ones, undermine government policies and distract public attention from the ways in which HIV is actually transmitted.

Although some of the effects of such attitudes can be addressed through human rights legislation, the only real remedy is a long-term program of education which addresses the facts about HIV transmission, the mistrust of medical science and a variety of deeply-held attitudes toward certain social groups.

AIDS education must reach many different audiences.

An effective program of AIDS education must reach a variety of audiences within Nova Scotia society. Reaching these audiences requires a two-tiered strategy of education for the general public and education for specific audiences. Specific audiences include the young, who must receive AIDS education in schools and universities, those with special needs and those who may engage in specific high-risk behaviors, who are in need of particular counselling and education. Young people who are sexually-active and currently outside the educational system are an important audience and particularly hard to reach. In order to reach all segments of society, programs of AIDS education should utilize community-based groups as well as the mass media and informal as well as formal means of communication.

The recommended programs of education and information form a mutually-reinforcing package. These programs must be co-ordinated with each other and with the variety of other sources, such as media and federal and American campaigns, from which Nova Scotians have received most of their information about AIDS.

The Task Force received a number of representations during its public meetings which emphasized moral aspects of the issues associated with HIV. These aspects are important considerations for many people. The Task Force believes they can best be addressed within families and by the efforts of the churches and religious communities in the province. As programs of AIDS education and information evolve, every effort should be made to keep churches and religious leaders informed so that they may play a supporting role by emphasizing for their members their views on the moral aspects of these issues.

AIDS Education for the General Public

The Task Force recommends a comprehensive provincial program of AIDS education and information for the general public. This program must promote public awareness of AIDS and an accurate understanding of how HIV is and is not transmitted. It should be based on a mass media campaign utilizing print and electronic media and the distribution of literature, as has already begun in Nova Scotia. Such a mass media campaign may be the only way to reach those who engage in high-risk behaviors but are unwilling to identify themselves by coming forward for counselling.

For this effort to have more than a superficial effect, there must be a long-term follow-up campaign, probably at a reducing level of intensity.

Recommendation 1

Under the aegis of the Nova Scotia Advisory Commission on AIDS:

a) A provincial multi-media campaign aimed at the general population should be developed and implemented in order to increase awareness and knowledge about AIDS.

b) Media campaigns should be co-ordinated by a public information committee which includes representation from the media and government. They should be modelled after those used for the Premier's task force on drinking and driving.

c) Follow-up multi-media campaigns should be developed and implemented to maintain the knowledge levels of the general population and reinforce the messages regarding how to prevent AIDS transmission.

d) **AIDS education guides should be made available to community-based service organizations that engage in community education programs.**

AIDS Education in the Workplace

Although mass media campaigns have great reach, they face limitations in discussing complex and sensitive issues such as AIDS. They provide no opportunity for discussion or questions. There are severe limits to what can be conveyed in a pamphlet or a 30-second announcement on television or radio. Because many Nova Scotians are still uncomfortable with open discussion of sexuality, a mass media campaign may be restricted in the information it can present.

Education can reduce potential disruption in the workplace.

Members of the general public need an opportunity to discuss AIDS with a knowledgeable person. AIDS education in the workplace can provide such an opportunity. Well-designed seminars of AIDS education in the workplace can provide factual information about AIDS, deal with unnecessary fears about HIV transmission in the workplace and help to reduce discrimination against workers who are HIV-infected. An effective program of AIDS education in the workplace can reduce the disruption which can arise when a worker is known to be HIV-infected. Most workplaces in Nova Scotia remain unprepared for this eventuality.

The Task Force recommends that the Government of Nova Scotia ensure the availability of AIDS education programs for the workplace and encourage employers to offer them. Unions and other employee organizations should be fully involved in the planning and implementation of these programs. Clearly, one of the best ways for government to encourage AIDS education in the workplace is to offer it to its own employees.

Recommendation 2

a) **AIDS education programs should be provided for public and private sector employees and employers. Whenever possible, existing programs should be used.**

b) **Employers should be encouraged to provide, or to permit public health officials to provide, AIDS education programs for the workplace.**

AIDS Education for Specific Audiences

Education and counselling for those who may be at high risk and hard to reach.

AIDS education must also address the needs of a variety of specific audiences. These audiences include many who may be likely to engage in certain high-risk behaviors.

Among specific audiences which must be reached with AIDS education are prostitutes, prisoners, street kids, intravenous drug abusers and bisexual and homosexual men. Individuals within these groups have an important need for education on preventing HIV transmission and may have a need for specialized counselling. In addition, they may be reluctant to come forward in search of information.

There is also a need for specialized AIDS education for groups such as the sight and hearing impaired, and other people with special needs, who for a variety of reasons may not be accessible through the mass media.

Community groups the best vehicle.

Experience in Nova Scotia and elsewhere indicates that the best way to reach these audiences is often through community-based agencies. Such agencies have the expertise and the trust of their clientele necessary to deliver the needed education on AIDS. They are an appropriate vehicle for providing highly-effective peer-to-peer education. The agencies and organizations to be involved in specialized programs of education may best be identified by the Advisory Commission on AIDS.

Recommendation 3

In order to meet the needs of high-risk, hard-to-reach and special-needs audiences, the Government of Nova Scotia should make available appropriate funding or resources to community-based organizations.

AIDS Hotline

AIDS hotline offers anonymity

A number of provinces and other jurisdictions have set up "AIDS hotlines." These are toll-free telephone services providing accurate information about HIV and AIDS and information on HIV-related services such as testing and counselling. An important feature is that they offer anonymity, without which some people with personal concerns about HIV infection might not seek information.

Experience with these services varies, but they seem to provide an important supplement to any public information campaign, particularly in its early stages. The use of such a hotline should be monitored to permit a regular review of its effectiveness.

Recommendation 4

A province-wide, toll-free AIDS hotline should be established to provide information and referrals to all Nova Scotians. The hotline should deal with enquiries on an anonymous basis.

In addition, the Task Force believes that education about HIV infection is needed for the personnel of existing hotline services in the province. These personnel will continue to receive some calls about AIDS whether or not a province-wide AIDS hotline is established. It is important that they be able to provide appropriate, reliable and consistent information.

Recommendation 5

All personnel of existing hotlines which have not been created to deal with AIDS should receive education on AIDS and the issues surrounding AIDS.

AIDS Education in the Schools

The need for AIDS education in Nova Scotia's schools and universities was one of the themes most emphasized during the public meetings held by the Task Force. For most Nova Scotians, concern about HIV infection is focussed on protecting the young.

Sexual activity among the young.

At the Fourth International AIDS Conference in Stockholm, Queen's University released preliminary results from its Canadian Youth and AIDS Survey. With support from the Federal Centre for AIDS of Health and Welfare Canada, the survey was conducted nationwide among 25,000 students in grades 7, 9, and 11 and students in their first year of university.

These results indicate that Canadian students are only moderately well-informed about AIDS. Their primary source of information about AIDS is television. That there is a need for AIDS education in the schools is indicated by the figures on sexual activity among students.

Among students nationwide in grade 9 (14 years old), 30% of the boys and 24% of the girls said they had had sexual intercourse at least once. For students in grade 11 (16 years old), the figures rise to 52% and 48% respectively. For students in first-year university (18-21 years old), 78% of the men and 74% of the women reported they had had sexual intercourse at least once.

Most sexually-active university students do not use condoms.

In relation to containing the spread of HIV, it is particularly disturbing that among sexually-active university students, 81% said they never used condoms. Eleven per cent said they always used condoms when they engaged in sexual intercourse. Three per cent said they used condoms most of the time and 5% said they used condoms some of the time.

With sexual activity a reality even among some students in junior high school, the Task Force recommends that compulsory, age-appropriate AIDS education begin by Grade 7 at the latest and continue through the post-secondary level.

AIDS education at every level of the educational system.

The Task Force endorses the Department of Education's "Personal Development and Relationships" program, which is designed for Grades 7 to 9 and includes education on HIV infection. The Task Force also endorses the Department's resources and guidelines for AIDS education in senior high schools and urges that all senior high school students receive appropriate AIDS education in addition to any AIDS education they may already have received.

The Task Force has made no recommendation about a formal program of AIDS education in elementary schools. The decision to offer such programs is currently made by school boards. However, the Task Force recommends that all elementary teachers receive the training necessary to allow them to respond accurately to any questions about AIDS which might be posed by their students. As noted earlier, 40% of the respondents in the survey supported a program of AIDS education in the elementary schools.

Parental review of materials.

Because of the sensitive nature of the sexual issues which are raised by AIDS education, the Task Force recommends that school boards provide parents with the opportunity to review and discuss with teachers the materials used in AIDS education. The Task Force believes such discussions might be useful in preparing parents for any discussion or questions about AIDS which arise at home.

Of all students, those at the post-secondary level are most likely to be sexually-active. Yet many students currently in post-secondary institutions have never received formal education about HIV infection. The Task Force recommends that the Department of Advanced Education and Job Training develop a program of AIDS education and make annual AIDS education compulsory for all students under its jurisdiction. The Task Force recommends that universities in the province assume responsibility for designing and offering to their students programs of AIDS education.

Finally, the Task Force recommends that teachers in public schools and community colleges, and those studying to be teachers, should receive the training they need to educate their students about AIDS. Those who are studying for the health and care occupations must also receive appropriate education about AIDS.

Recommendations will be implemented.

These recommendations on AIDS education in schools and post-secondary institutions were among 13 interim recommendations which were presented to government on May 19. The Departments of Education and Advanced Education and Job Training have responded favourably to these recommendations, which will be implemented in the 1988-1989 school year. The responses of the respective ministers are appended to this report.

Recommendation 6

The Department of Education should require that AIDS-specific information be a compulsory offering for all students beginning no later than Grade 7 and continuing through Grade 12.

Recommendation 7

a) **The Department of Advanced Education and Job Training should develop and require that annual AIDS-specific education be compulsory for students in institutions under its jurisdiction.**

b) **All universities and colleges in the province should assume responsibility for developing an educational program which will ensure that all students receive consistent and reliable AIDS information on an on-going basis. Where appropriate, consultation and advice should be provided through the Department of Health and Fitness, the Department of Advanced Education and Job Training, and other knowledgeable agencies.**

Recommendation 8

a) **Teachers in public schools and community colleges should be provided with appropriate in-service programs in AIDS education. The in-service programs must include basic knowledge on AIDS, updating on curriculum materials developed to deal with AIDS, and age-appropriate methods for teaching and dealing with AIDS-related issues and questions.**

b) **Institutions providing training for teachers, and for those to be engaged in the health and care occupations, should ensure these students are provided with appropriate AIDS education within their curricula. Where appropriate, consultation and advice can be provided through the Department of Health and Fitness, Department of Education, and the Department of Advanced Education and Job Training.**

Recommendation 9

All elementary school teachers should be provided with in-service training that will enable them to respond in an appropriate manner to the AIDS-related issues and questions of their students.

Recommendation 10

Within a structured parent-teacher environment, school boards should provide parents with an opportunity to review

and become familiar with the instructional materials to be used in the schools.

Ensuring Accurate Information

Education programs must be co-ordinated.

This comprehensive program of AIDS education and information will involve a wide variety of provincial departments, school boards and private groups, promoting AIDS education through a variety of media. Taken as a whole, this program must provide information which is consistent, accurate and current.

The Task Force recommends that the Nova Scotia Advisory Commission on AIDS take the leading role in co-ordinating the educational programs offered under the sponsorship of the Government of Nova Scotia. The Advisory Commission should also have the capability to respond to any inaccurate information which the public may receive. The Task Force has noted several instances in which misinformation about AIDS and HIV infection has been reported without correction in the Nova Scotia media.

Recommendation 11

The Nova Scotia Advisory Commission on AIDS should have responsibility for establishing:

a) a clearinghouse to make available up-to-date information on AIDS.

b) a mechanism to review the accuracy and consistency of educational materials produced under the sponsorship of the Government of Nova Scotia.

c) a mechanism to respond to inaccurate information publicized in the media.

3. Providing Care and Financial Support to HIV-Infected Persons

General Principles of Care

Infected persons can receive care and support within existing systems.

The Task Force believes that HIV-infected patients can and should be treated within the existing health care system in Nova Scotia. Health professionals have an important role in leading public attitudes toward those infected with HIV. They should treat HIV-related illnesses as they routinely do other blood-borne infections. When recommended infection control procedures are followed, HIV-infected patients can and should be treated in an atmosphere of normality.

The Task Force believes that AIDS will not put an inordinate burden on the existing health care system in Nova Scotia. We anticipate that the

number of AIDS cases will remain low in comparison to other diseases. Nova Scotia currently has the infrastructure to provide safe, quality care to persons infected with HIV and provide to health professionals appropriate training on HIV-related illnesses.

Recommendation 12

Health and care services should be provided within the context of existing health care programs and policies. Home care services should be co-ordinated through the home care program recently announced by the Government of Nova Scotia.

Hospital Care

Persons with AIDS require complex hospital care.

Persons with AIDS suffering from serious opportunistic infections require recurrent and sometimes prolonged hospitalization for the management of these infections. While hospitalized, these patients may need extensive care involving the services of nursing, neurology, dermatology, gastroenterology, psychiatry, surgery and neurosurgery, dietetics, social service, psychology and chaplaincy. In addition, out-patient service is required for the care of persons with AIDS and those with less-serious HIV-related illnesses.

Victoria General Hospital leading centre for treatment of HIV-related illnesses.

The care of Nova Scotians with HIV-related illnesses has been and remains centred in the Victoria General Hospital (VGH) in Halifax. Since February, 1983, the Infectious Disease Service at the VGH has treated 38 patients with AIDS. The VGH is the centre of excellence for the Maritime provinces for the treatment of HIV-related illnesses.

Currently, the VGH has about 30 patients with HIV-related illnesses receiving the drug AZT at a cost of $1000 per patient per month. Patients with HIV-related illnesses are treated on a regular basis by the out-patient service.

The Izaak Walton Killam Hospital for Children in Halifax is the only tertiary care pediatric centre in the Maritime provinces. Two cases of pediatric AIDS have been diagnosed at the IWK, one patient from Nova Scotia and one from New Brunswick. Both patients have complex medical problems which require frequent admissions to hospital.

Other hospitals have little experience.

A few other hospitals in Nova Scotia have treated patients with HIV-related illnesses. Primary care physicians and specialists throughout the Maritimes frequently seek assistance from the VGH in the management of AIDS cases. However, the routine management of HIV infection does not require the specialized services of the VGH. It seems likely that in the future, regional hospitals will care for straightforward opportunistic infections associated with HIV, while the VGH will continue to provide complex tertiary care.

Recommendation 13

The Department of Health and Fitness should ensure that hospitals receive sufficient resources to provide appropriate in-patient and/or out-patient care to persons with HIV-related illnesses.

Blood and Body Fluid Precautions

As described in Part I, HIV can be transmitted only if infected blood or body fluids enter the bloodstream of an uninfected person. The risk of transmission in the health care sector is low – less than 1% for needlesticks involving blood or body fluids which are known to be infected – but every effort should be made to make the health care setting as safe as possible for both patients and workers.

Blood and body fluid precautions long recommended.

Health professionals have developed procedures to minimize the risk of infection from organisms borne by blood or body fluids. Mostly because of Hepatitis B, which is potentially fatal and far more contagious than HIV, these blood and body fluid precautions have long been recommended. Unfortunately, they have not been applied as strictly as recommended in many health care settings.

Although such precautions have long been recommended, the appearance of HIV makes their application even more important. All workers in the health care and social services sectors must be properly trained in the application of blood and body fluid precautions.

When the proper blood and body fluid precautions are followed, HIV-infected patients can be treated without danger to health care workers or fellow patients. They do not require isolation or segregation within the health care setting.

Recommendation 14

AIDS should be treated using the normal infectious disease principles applicable to blood-borne diseases. It is not deemed necessary to establish specific AIDS units or wards independent of the normal infectious disease wards. Routine dental procedures should be provided in any dental office in the province. Where conditions warrant it, dentists should have the opportunity to use hospitals for procedures or patients requiring hospital facilities.

Over time, precautions should be used in the treatment of all patients.

Because a person may be infected with HIV for years before showing signs of infection, health care professionals may not know whether any given patient is or is not infected. Therefore, many experts believe health care workers should follow blood and body fluid precautions in the treatment of all patients.

This is known as "universal precautions." As defined by the Centers for Disease Control, universal precautions apply to blood, semen, vaginal fluid, tissues, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid. They do not apply to feces, nasal secretions, sputum, sweat, tears, urine or vomit, unless they contain visible blood.

The Task Force strongly supports the principle of universal blood and body fluid precautions. However, the implementation of universal precautions may take time and be costly. We believe this recommendation cannot be implemented without further study by the Advisory Commission on AIDS, in consultation with health care institutions and professional bodies.

In fact, the Medical Society of Nova Scotia and the Nova Scotia Dental Association are already promoting the use of universal precautions by their members. The Task Force believes there is also a role for other professional organizations and their licensing bodies, such as the Provincial Medical Board and the Dental Board of Nova Scotia, in supporting universal precautions.

There are a few other professions in which workers may regularly come in contact with blood and body fluids. In addition, occasional blood spills may take place in any public setting. The Task Force believes professional associations and individual institutions have the responsibility to implement proper precautions in the handling of blood and body fluids.

Recommendation 15

a) Universal blood and body fluid precautions should be implemented in all health care settings, including hospitals, offices of doctors and dentists.

b) The provincial government should request that the provincial regulatory bodies for health professionals support adherence to universal blood and body fluid precautions.

Need to Know in the Health Care Setting

Need to know only in order to provide appropriate care.

When appropriate blood and body fluid precautions are followed, HIV-infected patients pose no inordinate risk to health care workers. Therefore, only those who are providing direct care to an HIV-infected person need know his or her HIV status. This knowledge is required only in order to provide appropriate care.

There were suggestions made during the public meetings of the Task Force that patients have a right to know the HIV status of health care personnel by whom they are being treated. The Task Force believes that policies on HIV-infected personnel in the health care setting are best

determined by professional associations and individual health care institutions.

The Task Force also received recommendations that ambulance personnel, funeral directors and embalmers should be advised when health care personnel are aware of the HIV-infected status of a patient or a person who has died.

The Task Force believes that the concerns of persons in these professions would be better addressed through the adoption of universal blood and body fluid precautions as has been recommended by the Department of Health and Fitness. These precautions provide protection in all cases of HIV infection, including those in which health care personnel may be unaware that a person is HIV-infected. These precautions also provide protection against other blood-borne communicable diseases.

Recommendation 16

The only health workers who should be informed of a patient's HIV-infected status are those who provide direct care.

Testing for the HIV Antibody

As described in Part One, several types of blood tests now exist which can indicate the presence of the HIV antibody, from which HIV infection is inferred. A series of such tests can determine with a high degree of accuracy whether or not a person is infected with the virus.

Effective system of HIV testing must be based on trust.

The issue of HIV testing is a complex one, in which prevention, treatment and human rights are intertwined. For instance, mandatory testing or loss of confidentiality in test results are not just violations of human rights. They may also create fear and mistrust, which can cause those at risk of HIV infection to avoid the testing or counselling they need. In the current climate, even those who test negative may fear the social repercussions if it became known they had sought a test. A system of HIV testing should not have the effect of driving underground those most at risk, and perceptions which result in mistrust are as important as fact.

HIV testing has several different medical and public health objectives:

- aiding in the diagnosis of a patient;
- identifying and rejecting blood, tissues or organs donated by an infected person;
- identifying infected persons for the purpose of counselling;
- gathering epidemiological data to monitor the spread of the virus.

The Task Force recommends that the Government of Nova Scotia neither support nor allow mandatory HIV testing, except in relation to the donation of blood, semen, tissues and organs.

Mandatory testing neither ethical nor effective.

The Task Force does not support mandatory testing for the following reasons:

- Mandatory testing is not useful and does not promote prevention. A system of mandatory HIV testing does nothing to promote responsible individual behavior, which is the key to preventing the spread of HIV. In fact, it may have the opposite effect through creating a false sense of security. Because it takes at least several weeks for antibodies to develop, a negative result does not mean a person is uninfected even on the day on which the test was taken.
- Mandatory testing is self-defeating. The primary objective of any system of HIV testing is to counsel those who are infected or at high risk on how to protect themselves and/or others against HIV infection. Yet those who are at risk view mandatory testing with suspicion, perceiving it as the basis for restrictions on their rights. Those who most need testing will probably seek ways to circumvent a system of mandatory testing.
- Mandatory testing will involve great cost to identify a relatively small number of infected people. A system of voluntary testing is more cost-effective, ethical and rational.
- Mandatory testing is inconsistent with the right to privacy and has little countervailing public health benefit.

A system of voluntary testing is both ethical and, because it is trusted by those who may be at risk, more effective.

Recommendation 17

Mandatory testing should not be employed as a method of detecting or preventing the spread of HIV except in relation to donations of blood, sperm, or organs and other human tissues.

Testing system provides opportunity for counselling.

Face-to-face counselling for those who are considering being tested is one of the most effective techniques available to encourage changes in high-risk behavior.

Many of those who seek testing, although not all, are among those who most need to change their behavior to prevent HIV infection. Because they are worried about the possibility of infection, they can be counselled effectively on future behavior. For the reasons noted above, voluntary testing is more effective in this role than mandatory testing.

Pre-test counselling involves a full explanation of the testing system, how the results will be used and the possible ramifications of a positive test. Whether or not persons choose to be tested, and no matter what the result, those who seek testing will be counselled on high-risk behaviors and how to prevent infection. Counselling after a positive test also includes the offer of assistance in tracing and notifying previous sexual partners.

Recommendation 18

Pre-test and post-test counselling should be an integral part of any HIV testing.

Nominal Reporting and Anonymous Testing

Names of those who test positive reported to Department of Health and Fitness.

In Nova Scotia, HIV testing is voluntary but the names of persons who test positive for HIV antibodies must be reported by their doctor to public health authorities. This is known as a system of nominal reporting.

This system allows public health authorities to ensure that the sexual partners of people who are infected with HIV are traced and notified that they too may be infected. This is known as contact tracing, and it may be done by the person who has tested HIV-infected, the physician or a public health official. Currently, the Department of Health and Fitness contacts the physicians of infected persons and provides assistance with contact tracing if it is requested. Contact tracing is a long-standing public health measure for the control of contagious infections, particularly those which are transmitted sexually.

Mistrust of nominal reporting.

While the Task Force supports the existing system of nominal reporting, we also recognize that, as with a system of mandatory testing, there is a mistrust of nominal reporting. This mistrust centres on possible breaches of confidentiality and fears that in the future, records of the names of HIV-infected persons may be used to restrict rights. Fifty-eight per cent of Nova Scotians surveyed said they were not confident that in a system of nominal reporting, the names of infected person would remain confidential.

There is no evidence of breaches of confidentiality within the reporting system managed by the Department of Health and Fitness and there is not and should never be any plan to make use of nominal records beyond contact tracing. Nevertheless, there are perceptions of breaches of confidentiality and at least one case, that of Mr. Eric Smith, in which the confidentiality of a person's HIV status was breached at the level of his physician's staff.

System to offer non-nominal testing.

The undeniable mistrust of the current system of nominal reporting may deter those at risk of infection from seeking counselling or testing. Therefore, the Task Force recommends the creation of an alternative

system of testing and counselling in which the names of persons who test positive are not reported to the Department of Health and Fitness.

As within the regular system, pre-test and post-test counselling would be given and assistance with contact tracing would be offered to those who tested positive. Positive results would be reported without name to the Department of Health and Fitness for statistical purposes. This would not affect the current legal requirement for nominal reporting of all cases of AIDS diagnosed in the province.

Recommendation 19

a) Mandatory reporting of names of HIV-positive persons to the Department of Health and Fitness should continue to be required for the regular system of testing and reporting.

b) In addition, government should provide funds for the establishment and operation of an alternative system of testing and counselling in which the names of HIV-positive persons would not be reported to the Department of Health and Fitness. This should encourage voluntary testing and a more accurate statistical reporting of the incidence of HIV in the population. This mechanism should be operated by a community-based health service.

In addition, it is recommended that blood samples sent by a physician to a laboratory to be tested for the HIV antibody be labelled only with a code, a practice already encouraged by the Department of Health and Fitness. There is a perception that in at least one case confidentiality was breached by laboratory staff and fears about the possibility persist.

Recommendation 20

In order to reduce risks of breaches of confidentiality in the existing system for testing, means for coded testing should be encouraged.

Accuracy of Tests

Law inconsistent with current practice.

At present, there are two types of blood tests for HIV antibodies being used in Nova Scotia. The less expensive and less accurate ELISA test is the initial screening test. It may at times indicate incorrectly the presence of the antibody. Therefore, if the initial ELISA test is positive, it is followed by a second ELISA test. If that too is positive, it is followed up with the more accurate and more expensive "Western Blot" test.

It is the general practice in Nova Scotia to run consecutive ELISA tests and the Western Blot Test in one series from a single blood sample and to

complete the series before reporting any positive result to either the patient or the Department of Health and Fitness. However, Nova Scotia law as it stands technically requires nominal reporting after only one positive ELISA test. This is not now considered sufficient grounds for the reporting of HIV-positivity and no other province has this requirement. The Task Force recommends that the regulatory law be brought into line with current standards and practice.

Recommendation 21

Reporting of an HIV-positive result should occur only after a positive confirmatory test has been received.

Currently, all "Western Blot" testing and most ELISA testing in the Atlantic Provinces are carried out by the laboratory at the Victoria General Hospital in Halifax. Some ELISA testing is also done by the laboratory at the Halifax Infirmary. For the purposes of quality control and the protection of confidentiality, the Task Force suggests that these two laboratories continue to perform all testing for HIV antibodies for Nova Scotia.

Drug Costs

AZT provided free as part of clinical trial.

As noted, the anti-viral compound AZT is often prescribed for patients with AIDS. AZT is currently supplied to patients in Nova Scotia free of charge as part of a continuing "open trial" at the Victoria General Hospital. At present, the cost of other prescribed drugs is borne by the patient, averaging $100 to $200 per month.

The Task Force recommends that AZT continue to be provided to patients free of charge, as, for instance, the drug cyclosporin is provided free of charge to heart transplant patients. AZT is the best therapy now available to persons with AIDS, who may be young and without assets or health insurance plans. The Task Force also recommends that similar costly and vital drugs which may become available also be provided to patients free of charge.

Recommendation 22

The Government of Nova Scotia should ensure that AZT and other drugs which directly enhance an individual's ability to survive be made available free of charge to patients.

Home Care

Persons with AIDS have great need for home care.

Experience elsewhere has shown that for patients with HIV-related illnesses, as for many other patients, care is most compassionate when delivered to the greatest extent possible in the home. Because of the debilitating, long-term nature of their illness, AIDS patients have a great need for home care, which if available, can reduce their need for hospitalization.

There has been limited experience in Nova Scotia to date in providing home care to patients with HIV-related illnesses. Home care for persons with HIV-related illnesses has been noted to have sometimes been difficult to arrange. In some cases, it has been necessary to keep patients in hospital because they could not receive more or less routine care at home.

In the Fall of 1988, the Government of Nova Scotia will begin implementation of a new Co-ordinated Home Care program. This program will provide homemaker services and home health care. Depending on their general health, the type of opportunistic infection from which they suffer and whether they have other debilitating conditions, patients with HIV-related illnesses may need one or both of these types of care.

For patients who are on the "roller-coaster" of AIDS, there are periods during which they do not require hospitalization or full-time nursing, but lack the strength for cooking, cleaning, laundry, bathing, shopping and travelling alone to medical appointments. Homemaker service would provide assistance with these daily chores of home life.

During other periods, patients with HIV-related illnesses require nursing care in the home. For instance, a patient recovering from an episode of pneumonia would need home nursing care which provides intermittent monitoring of his or her condition. Other home nursing care might involve care, including palliative care, for patients who are in the terminal phase of the disease and are extremely debilitated. Effective home health care under these circumstances, however, usually requires that the patient have a viable personal support system with which the nurse can work.

The exact range of home nursing services to be offered under the Co-ordinated Home Care program has not been announced. The program cannot realistically be expected to provide full-time care, but it must be recognized that some patients with HIV-related illnesses live alone and have no one to provide them care.

Recommendation 23

Persons with HIV-related illnesses should be eligible for services provided through the Co-ordinated Home Care Program.

Persons with AIDS properly considered disabled.

The Co-ordinated Home Care program will give priority in its services to seniors, the disabled and "families at risk", although it has been stated that other groups in need are not excluded. Persons with HIV-related illnesses properly qualify as disabled persons. Although they may be only intermittently in need of home care, the Task Force believes that because of the recurrent need generated by their long-term affliction, they should be eligible for services provided by the Co-ordinated Home Care Program.

Recommendation 24

The priority assigned to applicants deemed eligible for Home Care Services should be determined on a case-by-case basis, taking into account the applicant's degree of need and whether or not the applicant has alternative potential providers of the needed services. The fact that an applicant's need for services is not likely to be continuous long-term treatment but rather temporary, and often repeated, should not affect the priority assigned to the applicant.

Nonetheless, care in the home for persons with HIV-related illnesses will continue to be provided often by loved ones. This is a demanding job, both physically and emotionally. During periods of acute illness or weakness, it is a full-time job.

When respite care is provided for the patient, it allows the lay care provider a needed period of physical and emotional rest. The person who is being cared for may be placed for a short time in a residential facility, such as hospital or Home for Special Care. Alternatively, he or she may be cared for in the home by a home care agency for a period of time.

Recommendation 25

The Government of Nova Scotia should ensure that reasonable respite care be available for persons with HIV-related illnesses who are being cared for at home. Respite care should be provided in whatever setting is appropriate and feasible.

Community Organizations

Community groups have been among the leaders in providing education and support.

Throughout North America, community organizations have played an important role in the fight against HIV. Some have formed within gay communities; others have been based in the wider community. They have offered sensitive and effective counselling and support to persons infected with HIV. To AIDS education for the general public they have brought the powerful perspective of intimate familiarity with the suffering caused by AIDS.

In Nova Scotia, the Metro Area Committee on AIDS (MACAIDS) has been the most important community group devoted specifically to helping persons who are HIV-infected and to fighting the spread of the virus.

The Metro Area Committee on AIDS provides a variety of services. It arranges professional counselling and support groups for HIV-infected people and their loved ones and is organizing a "buddy system" for persons with HIV-related illnesses. It maintains a library of current information on HIV infection and has provided speakers on the subject of HIV infection to interested groups. Private fund-raising, federal funding and recent funding from the Nova Scotia Department of Health and Fitness permit the Metro Area Committee on AIDS to maintain three full-time staff positions.

The Nova Scotia Persons With AIDS Coalition represents the concerns of HIV-infected persons in the province. The Nova Scotia PWA Coalition was formed in the Spring of 1988 to provide support and services to HIV-infected persons, particularly those with AIDS; to represent the interests of HIV-infected persons, and to provide HIV-infected persons the opportunity to become directly involved in issues arising from HIV infection.

Christians Assembled to Respond to AIDS (CARA) has recently formed and is actively involved with the Metro Area Committee on AIDS and the Nova Scotia PWA Coalition in a proposal for a residential hostel for HIV-infected persons.

Support for community groups one of the best ways to fight AIDS.

Experience elsewhere has shown that support for community groups such as these is one of the best ways for government to respond to the problems associated with HIV infection. Through their dedication, credibility and sensitivity, community groups can play a leading role in prevention of HIV transmission through education and information and in many aspects of support for HIV-infected persons.

Such community groups also represent for government an important reservoir of expertise and experience. In several instances, the Task Force has recommended consultation with community groups in the implementation of particular programs.

To date, most of the work of these community groups has been centred in Halifax/Dartmouth. There is need to support similar community services throughout the province, through additional funding to support the work of existing groups or funding to foster the development of new regional groups.

Recommendation 26

The Government of Nova Scotia should ensure that sufficient funds are available to permit existing community organizations such as MACAIDS and the Nova Scotia PWA Coalition to expand their operations beyond the metro area; or to facilitate the development of local voluntary

agencies providing educational and counselling services outside the metro area.

Support Groups

AIDS puts great strains on loved ones and caregivers.

HIV-related illnesses place a great strain on all concerned. Particularly in the absence of comprehensive home care, family, friends and lovers may be called upon to provide long periods of care and support. They suffer the emotional and spiritual strain of watching their loved one repeatedly face acute episodes of illness, knowing that one episode will finally prove fatal.

Under these circumstances, the loved ones of people with HIV-related illnesses need an opportunity to share their thoughts and feelings with others in the same position and with counsellors. They need clear and accurate information on providing safe, effective assistance.

Professional caregivers can also feel a great deal of stress in caring for patients with HIV-related illnesses, particularly people with AIDS. They must provide care that offers no hope of cure. They will develop relationships with patients whom they know face certain death. They must frequently deal with their own reactions to homosexuality and death, as well as the reactions and fears of their own family and friends.

Professional caregivers, as well as loved ones, need emotional support while caring for patients with AIDS. For loved ones, the Task Force believes it is community agencies which are best-equipped to organize support groups. For health care professionals, support groups may be organized through professional associations. Support groups are currently developing only in the Halifax/Dartmouth area.

Recommendation 27

The Government of Nova Scotia should fund community organizations such as MACAIDS and the Nova Scotia PWA Coalition to permit them to provide counselling and personal support to loved ones of persons with AIDS or HIV-positive persons. A "caregivers' network" may be the appropriate vehicle to deliver the counselling or support services.

Recommendation 28

A support group for health and other care providers who work with HIV-positive persons should be set up by a collaborative effort of the Medical Society of Nova Scotia, Registered Nurses' Association of Nova Scotia and the Nova Scotia Association of Social Workers.

Palliative Care

Palliative care is the co-ordinated, compassionate care of the terminally-ill. It is the care needed when medicine no longer offers the hope of cure or prolongation of life. Palliative care involves the management of suffering and assistance with the spiritual and emotional needs of a person facing death. It is multi-disciplinary care involving professionals, volunteers, family and community. It can be offered in the home, in hospital, in a long-term care facility or in a hospice.

At the Victoria General Hospital, palliative care is currently offered to persons with AIDS and to other terminally-ill patients. This service provides or co-ordinates counselling, education, advocacy, clinical expertise, volunteer co-ordination, home support and bereavement follow-up. Palliative care services are provided at some other hospitals in the province.

Palliative care still not widely available.

At present, only 10% to 15% of all terminally-ill patients in Canada have access to palliative care. There is a need for additional palliative care services for all terminally-ill patients, including those with AIDS. The Task Force endorses the model for palliative care outlined in *Caring Together*, the report of the Expert Working Group on Palliative Care to the Federal Centre for AIDS. The Task Force is encouraged that Halifax may be designated as a palliative care centre under this model.

The Task Force does not support the establishment at this time of a special palliative care facility for persons with AIDS. However, the Task Force supports the efforts of the Nova Scotia PWA Coalition, in association with other groups, to establish a residential hostel in Nova Scotia for HIV-infected persons. This hostel would provide a home for HIV-infected persons who, for medical, financial or emotional reasons, cannot or prefer not to live alone.

Recommendation 29

a) The Department of Health and Fitness should provide encouragement and assistance to hospitals throughout the province to establish palliative care services for all terminally-ill patients.

b) The Department of Community Services, together with the Department of Health and Fitness, should provide encouragement and assistance to Home Care workers to enable them to offer palliative care services.

Providing Financial Support

HIV infected persons may be unable to work for a variety of reasons.

Persons who are infected with HIV may be in need of financial assistance for several reasons.

Those with AIDS may simply be too sick to work. They are often young and without substantial savings, but the long-term nature of their disability may exhaust the financial resources of even those with significant assets.

Persons who suffer from AIDS or other HIV-related illnesses may for periods of time be healthy enough to work, but cannot maintain regular employment because of their periodic illnesses.

Nova Scotia has two interrelated systems of providing financial assistance to people in need. The province-wide system, known as Family Benefits, provides monthly payments to certain categories of persons whose need is likely to last for more than a year. The disabled, single parents, foster parents and senior citizens who are ineligible for Old Age Security payments are the groups generally eligible for Family Benefits.

Municipal Social Assistance (MSA) provides payments to those whose need is likely to last less than a year, and those who need longer-term support but are ineligible for Family Benefits.

Provincial Social Assistance

The largest group of recipients of Family Benefits – 61% – are those categorized as disabled. The category of "disabled" applies to those who have a physical or mental impairment which is likely to last for at least a year and which makes them unemployable in the regular job market.

Although persons with HIV-related illnesses may suffer acute episodes of illness only periodically, the Task Force believes that the employment problems which can be caused by HIV infection, as described above, qualify HIV-infected persons for Family Benefits as disabled.

Recommendation 30

The Department of Community Services should ensure that staff of the Family Benefits Division interpret Family Benefits Regulations in such a manner that does not deny benefits to HIV-positive persons in need and unable to obtain or maintain employment due to their medical condition/prognosis.

Prescription drugs should be provided for under Family Benefits.

At present, the Department of Community Services does not include the costs of prescription drugs when it calculates the "regularly recurring needs" of an applicant for Family Benefits. For those whose monthly drug costs are high, such as persons with HIV-related illnesses, this leads to lower benefits or a denial of benefits, when income exceeds "needs" as defined. However, once an applicant is accepted for Family Benefits as "disabled", he or she receives a Pharmacare card in recognition of the essential nature and high cost of prescription drugs.

Recommendation 31

The cost of prescription drugs or medical supplies used on a regular, recurring basis should be classified as among the "regularly recurring needs" of Family Benefits applicants.

Municipal Social Assistance

The Social Assistance Act gives each municipality in the province the authority to create its own social services policy. Since some municipalities have common systems, there are 25 different Municipal Social Assistance (MSA) policies among the province's municipalities. Policies vary considerably regarding eligibility for and levels of assistance.

MSA provides the following types of financial assistance to persons in need:

a) Basic Assistance to cover on-going basic needs;

b) Special Needs Assistance to cover expenses such as special diets, dental care, essential transportation and prescription drugs. MSA recipients do not receive Pharmacare cards. Family Benefits recipients may also receive MSA Special Needs Assistance, depending on the social service policy of the municipality in which they live.

Special Needs Assistance is provided on a case-by-case basis. In the city of Halifax, there is no ceiling on the amount of Special Needs Assistance which may be paid to a qualified recipient. To date, MSA recipients in Halifax who are HIV-infected have all received Special Needs Assistance to cover the costs of high-protein diets, prescription drugs, medical supplies and a bus pass to facilitate travel to medical appointments.

Municipal Social Assistance may not meet need for nutritious diet.

However, levels of Basic Assistance and eligibility for Special Needs Assistance vary from municipality to municipality and may not meet the needs of persons with HIV-related illnesses. In particular, such assistance should meet the requirement for a nutritious diet, which is one of the few ways in which a person may be able to fight an HIV-related illness. In addition, unlike Family Benefits, social service policies in most municipalities require applicants to exhaust all their liquid assets before becoming eligible for support.

The Government of Nova Scotia has recently raised Family Benefits payments for food and has initiated steps to ensure that Municipal Social Assistance programs do the same.

Recommendation 32

a) The Government of Nova Scotia should establish a province-wide minimum for Municipal Social Assistance (MSA) Basic Assistance payments and this

"minimum" should be sufficient to meet the basic needs of recipients;

b) The same rules regarding limits on liquid assets should be applied to applicants for MSA as are applied to applicants for Family Benefits.

In-Home Support Program

The in-home support program makes cost-sharing available to municipalities which wish to provide financial assistance to families providing care in the home for an elderly or disabled relative who would otherwise require placement in a Home for Special Care.

Once again, the Task Force believes that persons with HIV-related illnesses may be classified as disabled, and that those providing them care in the home should be eligible under this program. In addition, the Task Force recommends that eligibility extend to all those who are providing care in the home, not simply family members.

Recommendation 33

The In-Home Support Program of the Department of Community Services should extend the eligibility criteria to include all full-time lay providers of home care to eligible persons.

AIDS Education and Training in the Health and Social Service Sectors

Treating HIV-infected patients requires special training.

The care and support of patients with HIV-related illnesses is a new challenge for the health care and social service professions. The care of persons with HIV-related illnesses requires the treatment of a wide variety of unusual symptoms, a non-judgemental relationship with the patient, an open-minded understanding of the psychological problems associated with HIV infection and an adherence to infection control procedures.

Most family physicians in Nova Scotia have not yet treated a known HIV-infected patient. Many hospitals outside Halifax have little or no experience with HIV-infected patients or the treatment of AIDS. Staff education is required in many hospitals, long-term care facilities, social service agencies and home care agencies.

It is essential that professionals across the full spectrum of care and support be educated in the medical, psychological and social ramifications of HIV infection, not only to provide proper care and support and to minimize the occupational risks of transmission, but to help shape community attitudes toward AIDS and persons who are HIV-infected.

The desire in all the health and social service professions for further education on HIV and AIDS was a recurring theme of presentations to the Task Force.

Efforts have begun but level of training remains inconsistent.

The health care professions have already begun a concerted effort to provide training and education relating to HIV infection. Medical and nursing schools are including HIV infection in their curricula. Both the Medical Society of Nova Scotia and the Nova Scotia Dental Association are holding well-attended seminars for their members on the treatment of HIV-infected patients. Nonetheless, the level of training on the treatment of HIV- infected patients remains inconsistent across the province.

Particular need for counselling.

For many reasons, counselling plays a vital role in the treatment of HIV-related illnesses. Counselling begins with the "worried well", who fear they may be infected and must decide whether to be tested. Whatever they decide, they will need information about how to reduce their possible high-risk behavior.

People who prove to be infected will want to know the facts about the disease. They will want to know the precautions they will have to take. They will be despondent and fear death. If there is a possibility they have infected others, they will feel guilty and dread telling them. They will fear losing their jobs and friends, and may consider suicide.

Those who develop AIDS currently face the certainty of an early death. Most are young. They may find themselves alone, without money or the possibility of employment. For them, the years that remain will almost certainly involve periods of acute illness and a gradual weakening toward death.

Counselling in all of these difficult circumstances requires detailed knowledge, a sensitive understanding of a variety of lifestyles and a non-judgemental relationship with the patient. Therefore, it is recommended that the health and social service professions seek the assistance of community groups such as the Metro Area Committee on AIDS and the Nova Scotia PWA Coalition, who have led the way in informed and sensitive counselling of people with HIV-related concerns.

Recommendation 34

A program should be provided by the appropriate agencies to enhance pre-service and in-service education to: physicians, dentists, nurses, home care nursing aides, first aid workers, homemakers, social service workers, hotline/helpline workers and lay providers of care.

The program should relate to:

a) basic information about HIV and AIDS,

b) the treatment and counselling of persons with AIDS and HIV-infected persons,

c) homosexual and bisexual lifestyles, and

d) **infection control procedures, including universal precautions.**

Appropriate community organizations such as MACAIDS and the Nova Scotia PWA Coalition may assist with the training of care providers.

At present, health professionals from throughout the Maritimes with specific questions about HIV infection often contact the Victoria General Hospital for answers. Such questions may relate to treatment, counselling or infection control procedures. There is need for a more formal mechanism to respond to these inquiries.

Recommendation 35

The Department of Health and Fitness should establish a mechanism for responding quickly to questions from health professionals about the care of HIV-positive persons.

Research

Medical Research

Nova Scotia's medical science community is well-placed to play a role in medical research relating to HIV infection. In Nova Scotia's universities and hospitals, medical scientists can take part in the effort to find a vaccine against HIV infection, a cure for AIDS and particularly, more effective treatments for HIV-related illnesses. Scientists and medical doctors in Nova Scotia are already involved in a number of studies and clinical trials relating to HIV infection.

Medical research should be undertaken as part of national program.

However, medical research on AIDS is a massive worldwide effort, and research carried on in Nova Scotia must be co-ordinated with national and international programs. Given the cost of such research and limited provincial resources, the Task Force believes that the primary responsibility for managing and funding medical research into AIDS lies at the federal level and that research should be undertaken in Nova Scotia as part of the national effort which is currently co-ordinated by the National Health Research and Development Program.

Recommendation 36

Medical research programs should be developed within the context of the National Research Program on AIDS and should include any unique presentations of the disease in Nova Scotia.

Epidemiological Research

Limited data on current spread of HIV.

It is vital to the fight against HIV infection to know with confidence at what rate and in what ways HIV is right now spreading in Nova Scotia. There are limitations on the information which can be derived from reported cases of HIV infection because only a small percentage of Nova Scotians has been tested for the HIV antibody and they do not constitute a representative sample of the population. Statistics on the number of people with AIDS give only a snapshot of how and at what rate HIV was spreading two to seven years ago.

Anonymous epidemiological surveys.

Because of high cost, inefficiency and the inherent violation of human rights, the Task Force does not recommend mandatory HIV-testing of all Nova Scotians. However, the Task Force does support the need for epidemiological surveys as recommended in *AIDS: A Perspective for Canadians*, a report of the Royal Society of Canada. Such an epidemiological survey would involve anonymous testing for the presence of the HIV antibody in blood samples from a representative cross-section of the Nova Scotia population. The information derived from such a survey could have important implications for prevention programs and plans for the provision of care.

Recommendation 37

Epidemiological surveys should be carried out to estimate the number of HIV-infected persons in Nova Scotia.

Psycho-Social Research

Attitudinal research.

The Task Force believes it would be worthwhile to study various psychosocial issues relating to AIDS and HIV infection. Certain attitudes toward HIV-infected persons and misconceptions about HIV transmission undermine prevention programs and cause unnecessary suffering for those who are HIV-infected and those who are perceived to be at risk.

These attitudes include the mistrust among a significant minority of Nova Scotians of the prevalent medical understanding of HIV transmission, unwillingness to accept the presence of HIV-infected persons in the community and the cultural response to homosexuality. Research into the underpinnings of such attitudes could play an important role in the design of programs of AIDS education.

Recommendation 38

Research should be encouraged in regard to the psychosocial aspects of dealing with AIDS.

Health Care Costs

Health care costs can only be estimated.

As noted in the introduction to Part II, it is not yet possible to estimate accurately the costs which in the future will be associated with HIV-related illnesses. These costs will depend primarily on the number of persons with HIV-related illnesses resident in Nova Scotia, which cannot be estimated precisely without epidemiological surveys as recommended above. In addition, the treatment costs of a single case of AIDS are still being studied.

The best estimate now available is that health care for a person with AIDS costs about $82,000 a year, which is consistent with the costs of other major illnesses. The Task Force expects that the costs of treating HIV-related illnesses will remain a relatively minor part of total health spending. Of course, the magnitude of health care costs caused by HIV infection will depend to a considerable extent on the success of prevention through programs of education and information. The Task Force recommends that the Advisory Commission on AIDS study and monitor the costs of treating HIV-related illnesses.

Recommendation 39

It is recommended that the Advisory Commission on AIDS develop a program in collaboration with others to monitor the costs of providing health and care services to HIV-positive persons. It is noted that there does not now exist sufficient data to allow reasonably accurate cost estimates to be provided to government. Since a number of Canadian researchers are attempting to collect this data, an attempt should be made to co-ordinate these efforts with the needs of Nova Scotia.

4. Ensuring Rights

In fact, three epidemics.

The World Health Organization describes the AIDS epidemic as, in fact, three separate epidemics: an epidemic of HIV infection, an epidemic of AIDS and an epidemic of fear and prejudice.

The appearance of a new, fatal infection for which no cure could be found was bound to shock a world which felt it was safe from epidemics, particularly the industrialized world. The result was bound to be widespread fear – some of it justified, some of it not.

Discrimination does not offer protection.

People have historically reacted to contagious infection by fearing those who may be carriers. It is only natural that people should give priority to protecting themselves and their loved ones against infection. But shunning, discriminating against or restricting the rights of HIV-infected persons does not offer that protection. There is overwhelming evidence that the virus is not transmitted through day-to-day non-sexual contact with infected persons. Our society has not felt the necessity to react

through restrictions or discrimination to an infection such as Hepatitis B, which is transmitted by some of the same routes as HIV, may also be fatal and is far more contagious.

Clearly, society has the right to be protected if possible against the spread of HIV. But neither legal restrictions on the rights of HIV-infected persons nor discrimination by their neighbours offers protection against HIV. In the overwhelmingly majority of cases, those who are at risk of HIV infection put themselves at risk through voluntary behavior, primarily sexual behavior. It is through education, not discrimination, that we can fight the spread of HIV infection.

A destructive combination of fear, prejudice and misinformation.

In the case of HIV, fear and misinformation are compounded by prejudice. The virus is perceived to be carried by certain persons whose behavior does not conform to many North American's moral values – homosexual and bisexual men, intravenous drug abusers and the sexually-promiscuous. This combination of fear, misinformation and prejudice is a strain to the fabric of society and damaging to the dignity and rights of persons. It is beyond dispute that in Nova Scotia, as elsewhere, persons who are infected with HIV or perceived to be at high risk have suffered from discrimination. Those who have any doubt about that need only read the section of this report entitled "Living with AIDS."

The vast majority of HIV-infected persons are highly concerned about the protection of others, are informed about unsafe activities and responsible in their behavior. How will any society judge itself when, through unfounded fear or prejudice, it adds to their suffering unnecessarily?

Major obstacles to the fight against AIDS.

In addition, the issue of rights and discrimination goes beyond simple justice. Breaches of confidentiality, social discrimination and fears of legal discrimination are major obstacles to controlling the spread of the virus through education and counselling.

Amendments to the Nova Scotia Human Rights Act

No justification for second-class citizenship.

Those who are infected with HIV should be guaranteed the full range of rights enjoyed by all Nova Scotians and protected against discrimination. Second-class citizenship for HIV-infected persons is not justified by benefit to public health and would damage the rights of all Nova Scotians.

The possibility of discrimination extends beyond those who are actually infected. Through unjustified fear of HIV transmission, it may extend to family, friends and even caregivers. Discrimination may also extend to those who are considered members of a "high-risk group" and are perceived to be infected.

Discrimination may extend beyond those who are actually infected.

The Task Force recommends that the Nova Scotia Human Rights Act be amended to include protection specifically for those who are infected with a communicable disease and who pose no significant risk to public

safety. This would include persons who are infected with HIV, including those with AIDS, and those who suffer from other diseases of concern to public health. This amendment should also extend protection to those who associate with infected people and those who are perceived to be infected.

This approach is consistent with the view of the Task Force that HIV infection should not be treated as a unique problem. In terms of prevention, treatment and the protection of rights, HIV should be considered as one of a number of similar infections, unique only in its recent appearance and the attendant social reaction. Protecting the rights of HIV-infected persons should be achieved in the context of protecting the rights of all those who have contagious infections who pose no significant risk to others.

Full range of rights.

This amendment should guarantee to individuals within these groups all rights covered by the Nova Scotia Human Rights Act. This amendment should ensure them the same rights enjoyed by other citizens to public and private services, including, but not limited to, appropriate medical and dental care, social services, housing and employment. Compliance should be monitored by the Nova Scotia Human Rights Commission.

The legal protection of the rights of HIV-infected persons will not in itself end discrimination against them. This will require a long-term program of education both on the facts of HIV transmission and on the importance of human rights.

Recommendation 40

The Nova Scotia Human Rights Act should be amended to include protection expressly for persons who have, who are perceived to have, or who associate with those who have a communicable disease and who pose no significant health risk as determined by public health officers.

In itself, however, this amendment may not fully protect the rights of HIV-infected persons.

Since the appearance of the virus, there has been a high incidence of HIV infection among homosexual and bisexual men. For many, there is still the perception of AIDS as a "homosexual disease."

Resolutions against homosexuals.

This perception and the unwarranted fear of transmission through everyday casual contact have led a few municipal councils to adopt resolutions that would preclude homosexual men from teaching in public schools. These resolutions may be a matter for further discussions among some municipalities and school boards in the province. A petition has been tabled in the House of Assembly threatening a boycott of schools in Cape Sable Island and the surrounding area if either homosexuals or HIV-infected persons are allowed to teach in public schools in the area.

Discrimination against HIV-infected persons on the basis of sexual orientation.

Assuming that human rights protection is provided for those who suffer from a communicable disease and pose no significant risk to others, it would be most unfortunate if this protection could be circumvented when those who are practicing discrimination justify it on the basis of sexual orientation rather than on HIV status. Unless discrimination based on sexual orientation is also prohibited, particularly in regard to employment, housing and services offered to the public, the protection of HIV-infected persons against discrimination may have no practical significance in a number of cases.

Prejudice against homosexual men is perceived as a basis of discrimination against people who are HIV-infected. Fear of AIDS has fueled discrimination against homosexuals. In a number of submissions to the Task Force, it was noted that discrimination on the basis of sexual orientation is linked to the issue of AIDS as a direct and significant effect of the syndrome. Like any other form of unwarranted discrimination, it is damaging both to those against whom it is directed and to the values of a democratic society.

Discrimination on grounds of sexual orientation is prohibited under human rights legislation in Quebec, Ontario, Manitoba and the Yukon. In view of public proposals that would sanction such discrimination in Nova Scotia in relation to teachers, it seems timely to extend the Human Rights Act in this province to preclude that.

Recommendation 41

That the Human Rights legislation be amended to preclude discrimination based on sexual orientation.

Protecting Confidentiality of Health Information

Breaches of confidentiality can have devastating effect.

The protection of confidentiality is an important principle of the health care system. In the current climate, it is particularly vital in cases of HIV infection. For persons who have tested HIV-positive, or have even sought a test, the unauthorized release of their names can have a devastating impact. The case of Eric Smith has become an example nationwide of the disrupting effects of a breach in confidentiality.

An obstacle to the testing system.

Aside from the simple issue of fairness and human rights, breaches in confidentiality have a devastating effect on the effective functioning of the testing and counselling system. Given the lack of a cure or specific treatment for infection and the possible consequences of a breach in confidentiality, it is not surprising that persons who fear their names will become public may choose not to seek testing or counselling.

Violations of confidentiality, actual or rumoured, that the Task Force is aware of do not involve alleged breach of responsibility by officers of the Department of Health and Fitness or of senior hospital staff. Rather they

appear to be traceable to employees in the general system of health care delivery, including the office of a physician.

Current legislation protecting the confidentiality of medical and health information includes for provincial employees the general prohibition against release of information provided by the Freedom of Information Act and a specific provision in the Health Act with reference to information relating to venereal disease. Under the Hospitals Act, provision is made for confidentiality of hospital records, violation of which may on summary conviction result in a fine of not more than $500. An individual harmed by wrongful release of confidential information may seek damages but proof of damage or loss may be difficult and costly in terms of legal fees. We propose that legislation be extended to cover all those who have access to medical records and that damages payable to the party injured by wrongful release of information be fixed by statute.

Recommendation 42

The Government of Nova Scotia should enact legislation imposing liability for breaches of confidentiality without proof of actual damage, where personal health information is released without authority of the person concerned unless otherwise authorized or required by law. Liability should be for a predetermined amount sufficiently large to act as a significant deterrent to such breaches. Statutory damages should be recoverable from anyone who was entrusted through their occupation with personal health information and is responsible for such breaches.

Warranted Disclosure of HIV Status

Rare justification for disclosure without consent.

There may arise rare individual cases in which disclosure of a person's HIV status is justified. The hypothetical case which has been most debated by the medical profession is that in which the regular sexual partner of an infected person is unaware of that person's condition and is in danger of infection.

The Task Force believes that physicians and public health authorities should have the right to disclose without consent a person's HIV status to a second party whom they believe is endangered by that condition, when they believe that disclosure will lessen the danger. Disclosure made under that reasonable belief should not be considered professional misconduct.

Recommendation 43

a) Provincial legislation should provide that, where a physician has a bonafide belief that an HIV-infected person may be dangerous to others, and that

disclosure of the patient's HIV status may minimize or prevent this threat, the physician may disclose such information to the person or persons in danger or to the Department of Health and Fitness without the consent of the patient and disclosure made under such a belief shall be considered privileged and shall not amount to professional misconduct.

b) Where HIV-positive individuals are known to the Department of Health and Fitness, disclosure of their status without consent should only occur where, in the opinion of the Department, the status or condition of a person may present a threat to the health of that person or others.

The Task Force has identified only one other circumstance in which disclosure without consent of a person's HIV status is warranted. This involves children who are HIV-infected and who are under the legal guardianship of a child welfare agency. Given the need for infection control procedures and the likelihood of severe illness, the Task Force believes that the agency should know the child's HIV status and inform prospective foster or adoptive parents.

Recommendation 44

Child welfare agencies should be advised of the HIV status of a child entrusted to their care so that they, in turn, might advise potential foster or adoptive parents prior to the placing or adoption of the child. Otherwise, only parents or legal guardians of children should be advised of a child's HIV status.

Quarantine and Isolation

Although such cases would be expected to be exceedingly rare, there must be a legal capability to deal with persons who are HIV-infected who willfully endanger others.

Prosecution under criminal law might be possible in certain cases, but the penalities generally available under the criminal code seem inappropriate. Penal institutions do not offer appropriate counselling and treatment for HIV-infected persons and may be a setting with unusual risks for infected persons and others. It would be more appropriate to deal with HIV-infected persons who willfully endanger others under public health legislation rather than under criminal law.

Current public health legislation allows public health officers to quarantine or isolate persons with communicable diseases if they deem it necessary for the protection of public safety. Clearly, the wholesale use of such measures would contradict all we know about HIV transmission and

all we believe about human rights. However, even the use of such measures in rare individual cases should be done only under the full protection of due process, and if necessary, the law should be amended to that effect.

Recommendation 45

Government should not quarantine or isolate persons having the Human Immunodeficiency Virus except in extraordinary cases. The general use of such measures in relation to HIV-positive persons would serve no useful purpose either in provision of treatment or in containing the spread of the virus. In those extraordinary cases where quarantine or isolation is deemed necessary, public health legislation should be administered, or should be amended to expressly provide procedures, in accord with safeguards of the individual consistent with modern concepts of fairness and due process.

The Presence of HIV-Infected Persons in the Educational System

An emotional issue.

Because of the emotional intensity with which this subject has been debated in Nova Scotia and elsewhere, the presence of HIV-infected persons in schools merits special attention.

Some school boards in the province have already adopted policies to deal with AIDS. Others have not. The Nova Scotia School Boards Association has recommended that there be a standard policy across the province. Universities and other educational institutions have begun to address the matter, but few have yet adopted policies.

Many people continue to fear involuntary transmission of HIV through everyday contact with infected people. It is only natural that, where such fear exists, it is amplified when a parent believes his or her child may be endangered. The presence of HIV-infected persons in the educational system, whether students or employees, has met considerable resistance in some places in North America, including Shelburne County here in Nova Scotia.

Children not put at risk.

The Nova Scotia Task Force on AIDS concludes that children are not put at risk in the school setting by a teacher or fellow student who is HIV-infected. We reiterate that in the seven years since AIDS was identified, there has not been a single recorded case of HIV transmission through everyday contact. No such transmission has taken place even among family members sharing a household.

The possibility of HIV transmission through casual contact with an infected person, in school or elsewhere, is very remote. It does not begin to compare even to the minimal risks which children take every day through

crossing a street, playing games or being driven in a car or a bus. The possibility can be reduced even further through a few, simple precautions in the few exceptional circumstances where emergency first aid or the clean-up of blood or other body fluids is required.

A model policy for school boards.

The Task Force has not recommended a mandatory province-wide policy on the presence of HIV-infected persons in the educational system. Rather, the Task Force has drafted a model policy which, if approved by government, might be circulated and commended for favourable consideration by school boards and other educational institutions. The Task Force believes that the process of considering such policies at the local level is a valuable educational exercise for community leaders and parents, and that policies arrived at locally will have stronger community support than those imposed from above. This has been confirmed in discussions with some school boards which have already adopted policies on the presence of HIV-infected persons.

This suggested policy guarantees the right of HIV-infected persons to work or attend class in educational institutions, except where the Department of Health and Fitness determines that the presence of that person might endanger his own health or that of others. In all cases, confidentiality should be maintained. This policy also includes reference to teaching programs and to infection control procedures in exceptional circumstances.

Recommendation 46

The following statement of policy is recommended as a model for the favourable consideration of school boards and educational institutions:

Preamble

Transmission of the Human Immunodeficiency Virus (HIV), the generally recognized causal factor in development of the Acquired Immune Deficiency Syndrome (AIDS), is not known to occur except thrc ıgh sexual intercourse with an infected person or through the transfer of blood or body fluids from an infected person into the blood system of another person.

There is no evidence of infection spreading through normal casual contact. Thus, a person who has the virus does not pose any significant risk to others in most work or service settings, including the normal educational setting.

Principles for Policy in Schools and Educational Institutions

Students

The identity of a student with AIDS or infected with HIV is to be kept confidential.

Students with AIDS or infected with HIV have the right to attend regular classes unless the Department of Health and Fitness advises otherwise.

Where the Department of Health and Fitness advises that the condition of a student with AIDS or infected with HIV poses a health risk to the student or to others so that continued attendance at regular classes is not appropriate, alternative instruction should be provided on a case-by-case basis.

Teachers and Other Staff

The identity of a teacher or staff member with AIDS or infected with HIV is to be kept confidential.

Teachers and other staff with AIDS or infected with HIV have the right to continue in their regular employment so long as they are able to perform their duties according to the terms of their employment, unless the Department of Health and Fitness advises otherwise. If they become unable to perform their duties, access to all regular staff benefits should be ensured.

Teaching Programs

Information on AIDS, transmission of HIV and its avoidance, should be provided in schools and other educational institutions for the benefit of students and through in-service programs for teachers and other staff. In public schools, curricula and materials should be provided in the same way as for other school programs.

In all educational institutions, sequential, age-appropriate programs should be offered each year.

Precautions for Students and Staff Exposed to Blood or Other Body Fluids

Maintenance of minimal risk of exposure to HIV in the regular operations of schools and other educational institutions requires simple precautionary measures. In the exceptional circumstance where emergency first aid or the clean-up of blood or other body fluids is required, precautions as outlined by the Department of Health and Fitness should be followed.

5. Providing a Co-ordinating Mechanism for the Fight Against AIDS

The response to the challenge of AIDS cannot be a matter only for government. HIV infection is something that concerns us all. There is a need to harness the human and financial efforts of government, industry, business, and the voluntary sector. Co-ordination of efforts is needed to:

- avoid duplication;

- minimize conflict among jurisdictions;
- ensure appropriate co-operation in education of the general public;
- provide liaison between government and non-government organizations;
- encourage the development of innovative projects.

Legislation enacted at the 1988 session of the Legislative Assembly provides for establishment of an Advisory Commission on AIDS with up to 13 members appointed by the Governor in Council to advise the Minister of Health and Fitness on matters referred to the Commission by the Minister.

The Nova Scotia Task Force on AIDS recommends that the Government of Nova Scotia designate the Nova Scotia Advisory Commission on AIDS as the provincial co-ordinating agency to:

- advise government on policies and programs related to HIV infection;
- foster links among resource groups and interested parties – governmental and private, local, national and international – and serve itself as such a link;
- act as a repository for current information on HIV infection and monitor information being presented to Nova Scotians on HIV infection.

Fight against AIDS a complex effort.

It is especially important that government programs be co-ordinated during their developmental and introductory phases. It is our view that the proposed Commission can foster the necessary co-ordination working with the various departments and agencies currently concerned with HIV infection, such as the Departments of Health and Fitness, Community Services, Education and Advanced Education and Job Training. Agencies which may also become involved include the Human Rights Commission, Civil Service Commission and Drug Dependency Commission.

The Advisory Commission, reporting through the Minister of Health and Fitness, should provide advice on all programs sponsored or delivered by government. Reports of the Advisory Commission should be provided to the group of ministers with departmental responsibilities for programs of AIDS education or that affect persons with AIDS or infected with HIV.

The Commission should also have the ability to develop specific program proposals which would be directed to the appropriate line agency so that they might be included in a line agency's programs and budgets for submission to the Management Board.

Federal/Provincial co-operation.

The Government of Canada is embarking on a number of programs with which provincial programs should be co-ordinated. These programs may provide education for the general public and specific audiences. The Government of Nova Scotia should be consulted on the timing and content of federal educational programs within the province. The Commission

should play a leading role in co-ordinating the federal and provincial efforts within Nova Scotia.

Officials of the Government of Canada have expressed a willingness to co-ordinate their programs with those implemented in Nova Scotia. The Task Force received funding for some of its activities from programs of Health and Welfare Canada. That assistance is greatly appreciated, and coordinated programming in the future may warrant federal support and could contribute to the effort to meet the challenges presented by AIDS in the national context as well as in the province.

A broad view of public health required.

In general, programs addressing the health problems of HIV infection require a broad approach to community health because of the social issues that it raises involving human rights, the workplace and societal attitudes toward alternate lifestyles. A community-based education approach is required to establish the links among various local groups which are needed for an effective response to the problems associated with HIV.

To meet these needs, the Commission should be supported by an appropriate secretariat. We think it important that the secretariat provide effective staff support for liaison with community groups who would be involved in AIDS education and information programming at the local level, and for maintenance of library and other materials for use by the Commission and for circulation to others involved across the province.

To enable government to assess the direction and quality of the work done by the Commission, it is suggested that appointments to the Commission should be for not more than three years, with a review after two years to determine its future.

Recommendation 47

The Nova Scotia Advisory Commission on AIDS should be a central co-ordinating agency for government policy, programs, and information on AIDS.

The Commission should also play a "linking" role among government and non-government agencies dealing with AIDS.

The Commission should be comprised of representatives from business, industry, community groups, the health and education sectors, and interested citizens.

The Commission should be established for three years, with a review of its mandate after two years.

Appendix

The Nova Scotia Task Force on AIDS

The Nova Scotia Task Force on AIDS was established by the Executive Council of the Nova Scotia Government and announced on October 16, 1987 by the Minister of Education. On November 6, 1987, the mandate, terms of reference and size of the Task Force were expanded to permit a wide ranging, full-scale review of all matters related to Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). To representation from the Nova Scotia Teachers Union, the Nova Scotia School Boards Association, the Nova Scotia Federation of Home and School Associations, the Department of the Attorney General, the Department of Health and Fitness, the Department of Advanced Education and Job Training, and the Department of Education were added the Medical Society of Nova Scotia, the Department of Community Services, the Registered Nurses Association of Nova Scotia, the Nova Scotia Federation of Labour, the Nova Scotia Association of Health Organizations, the Metro Area Committee on AIDS, and the Nova Scotia Dental Association. In addition, members from the private organizations were invited to send observers.

The Task Force was to report their findings, including such interim reports as the Task Force may determine, and make recommendations in order of priority to the Executive Council through the Minister of Health.

Terms of Reference

The Task Force was directed to:

a) Review policies and programs in the private and public sectors, in Nova Scotia and elsewhere, which relate to methods of identifying and responding to matters associated with the Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV) and preventive measures;

b) Study present methods of responding with compassion and confidentiality to the needs of persons with AIDS, their immediate families and dependents;

c) Make recommendations concerning the further strengthening of public information and education programs in Nova Scotia respecting AIDS and its prevention, the need for increased education about AIDS in public schools and post-secondary institutions, and generally take into account the best current experience and thinking in other jurisdictions and its application to Nova Scotia;

d) Review present policies and programs and study further measures which might be undertaken to limit the incidence and spread in Nova Scotia of AIDS;

e) Study the best means of promoting coordinated action by government and community groups so as to meet the requirements of those persons with AIDS needing public support;

f) Examine the need for a central AIDS research and resource centre;

g) Define a "need to know" policy with respect to people who work with or provide services to persons affected with AIDS or the HIV virus;

h) Consult with appropriate representatives of the Government of Canada concerning that authority's involvement in and responsibility for matters directed to be studied by the Task Force;

i) Analyse present and probable costs of care and treatment in relation to AIDS, and liaise, as appropriate, with the Royal Commission examining health care costs.

Members of the Task Force

Ms. Barbara Carbonell, Department of Community Services
Mr. Wayne Cochrane, Department of Attorney General
Mr. Robert Cook, Nova Scotia Association of Health Organizations
Mrs. Karen Willis Duerden, Nova Scotia Teachers Union
Dr. Macadam Duncan, Medical Society of Nova Scotia
Mrs. Marlene Grantham, Registered Nurses Association of Nova Scotia
Mr. B.R. Haines, Department of Education
Dr. William Hart, Metro Area Committee on AIDS
Dr. Gary Jackson, Nova Scotia Dental Association
Dr. P.M. Lavigne, Department of Health and Fitness
Dr. W. Andrew MacKay, Chairman
Ms. Barbara Millar, Department of Community Services
Dr. Jamie Muir, Department of Education
Mr. D. L. Mulrooney, Department of Advanced Education and Job Training
Mr. Eric Smith, Member at Large
Dr. Wayne Sullivan, Department of Health and Fitness
Ms. Kathie Swenson, Department of Advanced Education and Job Training
Mrs. Kathy Wells, Nova Scotia School Boards Association
Ms. Anne White, Nova Scotia Federation of Home and School Associations
Mr. W. Wilson, Department of Attorney General
Ms. Gwen Wolfe, Nova Scotia Federation of Labour

Observers

Ms. Glenda Cooper, Nova Scotia Federation of Labour
Dr. Donald P. Cunningham, Nova Scotia Dental Association
Mr. Scott MacNeil, Metro Area Committee on AIDS
Mr. William Martin, Medical Society of Nova Scotia
Mr. R.J. Morrison, Nova Scotia Teachers Union
Mr. M.J. Woodford, Nova Scotia School Boards Association
Ms. Shelley Zwicker, Registered Nurses Association of Nova Scotia

Staff Support

Mr. Jim Houston, Researcher
Ms. Suzanne Kinsman, Administrative Assistant
Mr. Melvin McLeod, Writer
Mr. David Stuewe, Secretary to Task Force
Ms. Maureen Summers, Researcher
Ms. Barbara Whitby, Researcher
Dr. Louis Vagianos, Director of Research

Special Support Staff

Dr. Barry Lesser, Researcher
Dr. L. Lynn McIntyre, Researcher

Method of Operation

General Objectives:

To prepare a report dealing with matters within its terms of reference in a manner that would assist government and which would provide a base for any ongoing operations which might succeed the Task Force, the Nova Scotia Task Force on AIDS agreed to pursue a plan of action which would:

- identify issues of concern
- suggest priorities among issues identified
- select from the issues identified as priorities those which can be dealt with effectively during the lifetime of the Task Force
- make suggestions and recommendations to government, after receiving views and comments from individuals and organizations across the province, on the basis of study and reflection by the Task Force

An initial target date for completion of the report was May 15, 1988. The date was changed to September as work schedules were refined. The Task Force met on an average of twice monthly with meetings averaging about four hours per sitting.

Plan of Action and Staff Support:

The Task Force was assisted in its deliberations by a small administrative and research group headed by a Director of Research, Louis Vagianos, and a Secretary, David Stuewe. These officers worked directly with members of the Task Force and were supported by one full-time Administrative Assistant and two researchers. The office was housed in temporary office space on the sixth floor of the Dennis Building, at George and Granville Streets. Other contract researchers and clerical help were hired as required.

Organization of Task Force:

The Task Force was divided initially into three working groups which together would be concerned with all of the matters included in the terms of reference:

1. Impact issues involving people who have developed AIDS, or tested HIV positive, including:

   - legal and ethical implications regarding the workplace, hospital and other institutions for care and social institutions

   - policies relating to immediate families, dependents, co-workers and health care workers.

2. Requirements for and types of public information programs, including:

   - recommendations as to what information should be included in a public information campaign which can be of use to all citizens, regardless of status and condition, and particular target audiences, such as students and groups associated with high risk activity.

   - identification of information which should be distributed widely and which should be readily available to help educate the public as to the nature of AIDS.

   - suggestions as to the type of outlets and coordinating mechanisms which might be needed on a permanent basis for a continuing program of public education.

3. Public and private health care:

   - health care and other costs now or to be anticipated in the future for treatment and care in relation to PWAs and their families.

As noted above, members of the Task Force were asked to serve on one of the initial working groups.

It was assumed that each workgroup would work independently but that all members of the Task Force would receive material deemed useful to the group as a whole. More important, the entire Task Force would be involved in the preparation of final documentation for government.

The process of preparation for the final report was straightforward: suggestions and recommendations should emerge from each sub-group, from any consultants, invited presentations, and other interested parties, and would be discussed by the full Task Force. Summary discussion papers would then be written by the support staff for consideration, and as general agreement was reached, final, more polished documents would be prepared for consideration and inclusion in the final report.

Public Meetings

The Nova Scotia Task Force on AIDS held public meetings throughout the province during the month of March. The primary purpose of the Task Force's public meetings was to permit members of the Task Force to listen to Nova Scotians' views and concerns about AIDS. In fact, at each meeting, presentations to the Task Force were made by community leaders and individuals. There was also an opportunity for members of the audience to express their views and to ask questions.

In all, 15 locations were visited:

March 7 - 11
- Sydney
- Port Hawkesbury
- Antigonish
- Dartmouth

March 14 - 18
- Digby
- Yarmouth
- Shelburne
- Clark's Harbour
- Bridgewater
- Liverpool

March 21 - 25
- New Glasgow
- Truro
- Amherst
- Wolfville

March 28 - 31
- Halifax

Listing of Briefs Presented to Task Force

The Public Meeting Phase of the work of the Nova Scotia Task Force on AIDS took place during the month of March, 1988. In all, 20 meetings were held in 15 locations around the province, those being: Dartmouth, Antigonish, Port Hawkesbury, Sydney, Digby, Yarmouth, Shelburne, Clark's Harbour, Liverpool, Bridgewater, Wolfville, Truro, New Glasgow, Amherst and Halifax. Public information sessions preceded the meetings and were staffed by personnel from regional Health Units of the Department of Health and Fitness.

Ninety-one briefs were presented at these meetings, with 12 more submitted later. In addition, approximately 60 oral presentations were made at the meetings, for which no text was submitted. Those making presentations ranged from community, government and business leaders to representatives of volunteer organizations, professional associations, unions and members of the general public. A list of all briefs submitted is provided below; those briefs that were received but not actually presented during public meetings are noted with an asterisk. All briefs will be available from the Nova Scotia Advisory Commission on AIDS.

Briefs Presented to Task Force at Public Meetings

Submitted at	Organization Represented	Presenter
Amherst	Family & Children's Services of Cumberland County	Mr. David Dinaut, President
	The Medical Society of Nova Scotia	Dr. Vonda Hayes
	Not identified.	Mr. Con Desplanque*
Antigonish	Antigonish District School Board	Mr. Charles Curry, Chairman
	Antigonish Right To Life	Ms. Ramona MacDonnell
	Antigonish Women's Association	Ms. Lucille Harper
	The Medical Society of Nova Scotia	Dr. Erich Sperker
	Students' Union of Nova Scotia	Mr. Royden Trainor, Chairman
Bridgewater	Canadian Union of Public Employees	Mr. Robert Wells, Health and Safety Representative, Atlantic Region
	Chester Board of Health	Dr. Donald V. Wright*
	County of Lunenburg Ecumenical Fellowship	Rev. Allie Leitzel
	Evangelical Lutheran Church in Canada	Rev. Allie Leitzel
	The Medical Society of Nova Scotia	Dr. Anthony R. Atkinson
	Second Story Women's Centre	Ms. Phyllis Price
Clark's Harbour	Barrington Municipal Council	Ms. A. Reynolds, Councillor Mr. G. Newell, Warden
	The Progressive Conservative Association of Shelburne	Mr. Wayne S. Rideout, President
	Town of Clark's Harbour	Letter received and read at the meeting by the Chairman.
	United Concerned Parents of Cape Sable Island	Ms. Linda Swim
	Western Health Unit, Nova Scotia	Dr. Lamont Sweet
	Department of Health & Fitness	
	Not identified	Mrs. Joan Czapalay
Dartmouth	City of Dartmouth	His Worship John Savage, Mayor
	Dartmouth District Council of Home and School Associations	Mr. Danny Walton, Chairman
	Dartmouth District School Board	Ms. Sandra Everett, Chairman

	Leader of the Opposition	Dr. James Smith for Hon. Vincent MacLean
Digby	McCleave Medical Centre	Dr. William Thurlow
	Western Health Unit, Nova Scotia	Dr. Lamont Sweet
	Department of Health & Fitness	
	Not identified	Mr. Richard H. Applejohn*
Halifax	Ambulance Operators Association of Nova Scotia	Mr. Robert Schaffner, President
	Anglican Diocese of Nova Scotia	The Rt. Rev. A. G. Peters
	Atlantic Gays and Lesbians in Health and Social Services	Mr. Ken Belanger
	Bible Baptist Church, Greenwood Village Bible College and Academy and the International Christian Mission	Dr. William J. Moorehead, Pastor, Bible Baptist Church, (Ind.)
	Canadian AIDS Society	Mr. Michael Sobota for Board of Directors
	Canadian Federation of Independent Business	Mr. Peter O'Brien, Director Prov. Affairs-Atlantic Canada
	Christians Assembled to Respond to AIDS	The Rev. Robert Petite
	Church and Society of Maritime Conference of the United Church of Canada	Ms. Adele Peckford, Church in Society Conference
	Dalhousie Law School, Dalhousie University	Prof. Philip Girard and Prof. Wade MacLaughlin
	Dalhousie Legal Aid Society	Ms. Maureen Shebib and Mr. Jack Graham
	Federation of Foster Parent Associations of Nova Scotia	Ms. Pauline Johnson, Executive Director
	Freelance writer	Mr. Robin Metcalfe
	Gay Alliance for Equality	Ms. Gillian Baines and Mr. Shawn F. Cox
	Halifax County - Bedford District School Board	Mrs. Lois Wiseman, Chairman, and Mr. Lloyd Gillis, Chief Education Officer
	Halifax District Parent-Teacher Association	Mrs. Wendy Rogers, President
	Halifax District School Board	Mrs. Nita Graham, Vice-Chairman
	Independent Baptist Pastors	Rev. Roland L. Smith, D. D
	Lesbian and Gay Rights of Nova Scotia	Ms. Anne Bishop
	Maritime School of Social Work, Dalhousie University	Ms. Brenda K. Richard, Associate Professor
	The Medical Society of Nova Scotia	Dr. Vincent P. Audain, President Elect

	Metro Area Committee on AIDS	Ms. Madeline Comeau, Executive Director
	Metro Community Law Clinic	Mr. Darrell H. Martin
	Nova Scotia Advisory Council on the Status of Women	Ms. Debi Forsyth-Smith, Chairman
	Nova Scotia Association of Social Workers	Ms. Marilyn R. Peers
	Nova Scotia Dental Association	Dr. W. A. Maillet, President
	Nova Scotia Family and Child Welfare Association	Ms. Elsie Blake, Executive Director
	Nova Scotia Health Record Association	Ms. Gail Gray, Director of Medical Records
	Nova Scotia Human Rights Commission	Ms. Janet McKinnon, Human Rights Officer
	Nova Scotia Licensed Embalmers' and Funeral Directors' Association	Mr. Robert Schaffner, Executive Director
	Nova Scotia PWA Coalition	Mr. Peter Wood*
	Nova Scotia Restaurant and Food Services Association	Mr. James R. Legge, Executive Director
	Planned Parenthood Association of Dartmouth and Halifax County	Ms. Saundra Hardy
	Planned Parenthood Association of Nova Scotia	Ms. Mary Hamblin and Ms. Kathy McKay
	Roman Catholic Archdiocese of Halifax	Archbishop James M. Hayes
	Victoria General Hospital	Dr. T. J. Marrie, Chief, Infectious Diseases, Professor of Medicine, Dalhousie University, and Dr. Scott Halperin, Izaak Walton Killam Hospital for Children
	Women's Action Coalition of Nova Scotia	Ms. Deborah Trask, Chairman, Health Committee
	Women's Alliance in Support of Prostitutes and Stepping Stone	Ms. Anne Derrick
	Not identified	Anonymous*
	Not identified	Anonymous*, Pictou County
	Not identified	Ms. Beverley Cassidy*, Dalhousie University
	Not identified	Mr. Raymond Hunter*
	Not identified	Ms. Monica MacLean, student, School of Education, Acadia University
Liverpool	Municipality of the County of Queen's	Mrs. Lynn Whynott, Councillor, Ad Hoc Committee
	Queen's District School Board	Ms. Linda Hupman, Chairman

New Glasgow	J.U.S.T. Women	Mrs. Pamela MacDonald
	Pictou County Medical Society	Dr. Richard Felderhoff
	Pictou County Women's Center	Alexandra Keir
	Not identified	Mr. Edward MacIntosh, Resident of Stellarton
Port Hawkesbury	Richmond District School Board	Mr. James Burton, Curriculum Supervisor, and Ms. Dolores Maltby Boudreau, member
Shelburne	Roseway Hospital	Mr. H. C. MacKay*, Executive Director on behalf of Infection Control Committee, and Ms. Linda Maclachan, Infection Control Nurse
	The Shelburne County Children's Aid Society	Ms. Madelyn LeMay
	Shelburne County District School Board	Mr. Owen G. Wheelock, Superintendent of Schools, and Mr. John McKenney
	The Shelburne County Ministerial Association	Rev. John Earle and Rev. James Hicks
	Shelburne Town Council	Mrs. Carol Oxner
	Town of Lockeport	His Worship L. M. Huskilson*, Mayor
	Western Health Unit, Nova Scotia Department of Health and Fitness	Dr. Lamont Sweet
	Not identified	Dr. Ian Campbell Cree, MB, MS, FRCS (Eng), FRCS (C), FACS
	Not identified	Mrs. Joan Czapalay
	Not identified	Mr. Stephen Czapalay
	Not identified	Mr. Robert W. Grovestine*
Sydney	Cape Breton District School Board	Mr. Adrian Bates and Ms. Myrtle Campbell
	Diocese of Antigonish	Rev. Raymond Huntley, Director of Youth Ministry
	Family Planning Resource Team	Ms. Kathy Penny and Ms. Sharon Forese Neilson
	The Medical Society of Nova Scotia - Sydney Branch	Dr. Alan N. Freeman, President
	National Action Committee on the Status of Women	Ms. Patricia Campbell, N.S. Representative
	Northside-Victoria District School Board	Dr. Thomas J. Gaskell*, Superintendent
	Not identified	Dianna Denny
	Not identified	Gloria Gould

	Not identified	Marie Horecnuk
	Not identified	Doug Ivany
Truro	Cobequid Health Unit	Dr. Donald B. Langille, M.D., M.HSc., Director
	Colchester Regional Hospital	Mr. Paul Brown, Administrator
	Concerned Independent Pastors of the Truro Area	Revs. G. J. Lidstone, P. Pardoe, E. Hodgkins, J. Luten
	N.S. Family and Child Welfare Association	Mr. Loubin Bourque, Executive Director, Family and Children's Services of Hants County, and Ms. Pauline Johnson, Executive Director Federation of Foster Parent Association of N.S.
	Women's Health Education Network	Ms. Margaret Grant
	Not identified	Ms. Suzanne Wheeler, Grade XI student, Cobequid Educational Centre
Wolfville	Acadia University	Dr. J.R.C. Perkin, President and Vice-Chancellor
	Department of Sociology, Acadia University	Mr. Blye W. Frank, Lecturer
	Fundy Health Unit	Mrs. Phyllis A. Sweet, Family Planning Nurse
	King's County District School Board	Not identified
	The Medical Society of Nova Scotia	Dr. J.D.A. Henshaw
	Valley Health Services Association	Not identified.
	Not identified	Ms. Pauline Cudmore, student, Acadia University
	Not identified	Ms. Jennifer Faulkner and Mr. Jamie Wright, Grade XII, Horton District High School
	Not identified	Mrs. Sylvia Henshaw
	Not identified	Mr. Sweet
Yarmouth	The Medical Society of Nova Scotia	Dr. Shelagh Leahey
	The United Church of Canada	Not identified.
	Western Health Unit, Nova Scotia Department of Health and Fitness	Dr. Lamont Sweet

Oral presentations made at the Public Meetings (no text submitted)

Amherst	Cumberland District School Board	Mr. Gary Miller, Supervisor of Secondary Education, and Dr. David Rippey, Medical Consultant
	Springhill Chamber of Commerce	Mr. Don Hamilton, President
Antigonish	Children's Place Day Care	Mrs. Sarah Stouffer, Administrator
	Not identified	Dr. John Chaisson
Bridgewater	Chester District Elementary School	Mr. Peter Oikle, Chairman, Association of Health Educators
	Lunenburg County District School Board	Mr. Lloyd Campbell, Assistant Superintendent of Schools
Clark's Harbour	Town of Clark's Harbour	His Worship Michael Nickerson, Mayor
Dartmouth	Dartmouth General Hospital	Mr. Donn Peters, Executive Director
	Dartmouth Public Library	Ms. Linda Pearse
Digby	Annapolis District School Board	Mr. J. L. MacDonald, Superintendent
	Digby District Local, N.S.T.U.	Mr. William Redden, President
	Digby District School Board	Mr. William Pyle, Superintendent
	Digby General Hospital	Mr. Ralph G. Stacey, Administrator
	Homemaker Services of Digby County	Mr. Greg Wiseman, Supervisor
	Not identified	Ms. Glenda Doucette Boudreau
Halifax	Town of Bedford	His Worship Keith Roberts, Mayor
	Not identified	Ms. Christine Brush, Shelburne County
	Not identified	Mr. Bruce Davidson
	Not identified	Ms. Shirley Doucet-Boyle
	Not identified	Ms. Catherine Hughes
Liverpool	Family and Children's Services of Queen's County	Mrs. Jean Strum, Treasurer
	South Queen's Chamber of Commerce	Mr. David Randall
	Town of Liverpool	His Worship Ron Lane, Mayor
New Glasgow	Aberdeen Hospital	Ms. Muriel MacLean, Infection Control Nurse

	Pictou County District School Board	Mr. Allan MacDougall
	Pictou County District School Board	Dr. Ellen MacLean
	Pictou County Women's Centre	Ms. Colleen Popowich
	Town of Stellarton	His Worship Ron Marks, Mayor
	Not identified	Rev. Peter Fraser
Port Hawkesbury	Inverness Consolidated Memorial Hospital	Ms. Betty Jane Cameron
	Inverness District School Board	Mr. Leonard Kuniski, Superintendent
	Inverness District School Board	Mr. Charles MacDonald, Chairman
	Richmond County	His Worship James Goyetche, Warden of Richmond County
	Strait-Richmond Hospital	Mr. Mark Rubenstein, Administrator
	Town of Port Hawkesbury	His Worship Almon Chisholm, Mayor
Shelburne	Lockeport Baptist Independent Church	Rev. William Bump
	Town of Shelburne	Mr. Carl White, Member of Council
	Not identified	Mr. Thomas Humble
Sydney	City of Sydney	Alderman Adrian Smith, Chairman, Board of Health
	University College of Cape Breton	Rev. Bedford Doucette, Chaplain
	University College of Cape Breton	Mr. J. J. MacNeill
	University College of Cape Breton	Dr. William Reid, President
	University College of Cape Breton	Prof. James St. Clair
	Sydney City Hospital	Ms. Mary McIsaac, Director of Patient Care Services
Truro	Nova Scotia Teachers' College	Ms. Margaret Swan, Principal
Wolfville	Acadia University	Dr. Norman Watt, Director, Extension Department
	Eastern King's Memorial Hospital	Ms. Sheila Ley, Laboratory Technician
	King's County District School Board	Mr. Harry Bill
	Town of Kentville	His Worship R. Wendell Phinney, Mayor
	Valley Health Services Association	Mrs. Lynn Randall
	Not identified	Mr. Douglas Milligan
Yarmouth	Clare-Argyle District Local, N.S.T.U.	Mr. Roland Surette, President

Clare-Argyle District School Board	Mr. Stan Surette, Superintendent
Department of Community Services, Yarmouth Regional Office	Mr. Glenn Cronk
Nova Scotia Council on the Status of Women	Mrs. Pauline d'Entremont
St. Joseph du Lac	Sister Estelle Arsenault, Administrator
Town of Yarmouth	Her Worship Marjorie McEachern, Mayor
Yarmouth District School Board	Mr. John Daley, Superintendent
Yarmouth District School Board	Mr. Charles McConnell, Chairman
Not identified	Rev. John Wilson

Selected Commentary from Presentations to the Public Meetings of the Nova Scotia Task Force on AIDS

We believe legislation should be introduced requiring physicians and hospital authorities to notify ambulance personnel when a patient who has AIDS is being transported by ambulance. We are not asking that we be told the patient has AIDS but that he or she has an infectious disease and that we should take special precautions.

Ambulance Operators Association of Nova Scotia

The Antigonish District School Board firmly believes that a universal or Provincial policy is a must with respect to the AIDS crisis. A standardized policy would add strength and credibility in dealing with those infected with the virus and those not infected. The Board also believes that the formulation of such a policy must take place now so that the guidelines to deal with an AIDS-related issue are developed under calm and well-structured circumstances as opposed to being formulated under a crisis and/or reactionary situation.

Antigonish District School Board

It has long been recognized that good morals make good medicine and that good medicine makes good morals. Yet, today we hear public health officials saying that AIDS is a life and death issue, not necessarily a moral issue. Are we prepared to risk total erosion of our health care system by abdicating our social and moral responsibilities. . . . We agree that the rights of the AIDS carrier must be protected to a point; however, is the AIDS carrier to enjoy total protection of his or her civil rights at the expense of unnecessarily endangering others?

Antigonish Right to Life

We need to dispel the myths that AIDS is a gay disease and that it is spread by casual contact. The fear of AIDS can be as damaging to society as the disease itself unless it is addressed clearly, concisely and factually in a humanitarian way.

Antigonish Women's Association

Parents and concerned groups have approached Council for our support for their concern about AIDS and AIDS virus. As elected representatives of the people of the Municipality, we feel it is our duty to share their concern. We feel that a person carrying the AIDS virus is in a high risk group and since children are involved, we do not feel that any risk to endanger their health should be taken. . . . Many are confused, even frightened in the face of the growing AIDS epidemic. They fear we may not know enough about the AIDS virus and modes of transmission to avoid becoming infected. . . . In summary AIDS is a disease overwhelmingly related to specific lifestyles and actions – to activities that a person can be educated to avoid and must discipline himself or herself in that direction.

Barrington Municipal Council

Traditional health organizations have been unable or unwilling to meet the urgency of frank educational methods and materials. When people are dying, AIDS education and prevention messages have too often been blocked by conservative attitudes and moralizing. Community groups have a demonstrated record of cutting through such blocks and have pioneered frank exchange about sexuality, homosexuality, health, illness and death in our time. Community groups are best suited for this type of non-judgemental service delivery. Addressing the fears of the worried, developing safer-sex education programs and providing direct counselling and support services to persons with AIDS – all requires non-judgemental response.

Canadian AIDS Society

In health care facilities our members have often felt that they were treated as second class citizens. This has been reinforced by housekeeping and dietary workers not being told when isolation procedures were suspected as being necessary. Often they were shocked when leaving patient rooms to discover that the medical staff were entering the same room masked and gowned and no one has advised them of the need.

Canadian Union of Public Employees

Many persons with AIDS find themselves without financial resources due to loss of employment and are unable to find adequate housing. Persons with AIDS also experience special problems of adjustment to the medical and social implications of this disease and therefore require the kind of support which can be offered by a residence dedicated to their particular needs.

Christians Assembled to Respond to AIDS

Educators, health professionals, parents and the community at large must be knowledgeable about this disease and teach our children about it in time to take effective precautions. Given the right measures, no one need get AIDS and only by acting upon accurate AIDS information can people protect themselves, their sex partners, families and ultimately society from this disease. . . . We realize that students need accurate, explicit, comprehensive information about AIDS – its causes, its effects, modes of transmission and its prevention. Besides presenting factual information and dispelling myths, we try to provide students with ample opportunity to discuss their feelings, to identify some of the implications for society and individuals, and to be aware of sources in the community which can be contacted for reliable information.

Dartmouth District School Board

Advertisements and brochures need to be frank in discussing safer sex. It would seem to be counter-productive to worry about offending a few people with frank ads when such ads would assist in saving the lives of our youth.

Family Planning Resource Team, Sydney

AIDS is a deadly disease and one which has been tragically stigmatized through the actions and expressions of fearful and often misinformed individuals and groups. Its victims have been pre-judged, isolated, rejected and verbally, physically and emotionally violated. It is time that the morality of AIDS be placed aside. Focus and energy must be centered on the provision of compassionate service delivery and care to victims and the development of a comprehensive public education program to prevent the spread of HIV infection.

Federation of Foster Parent Associations of Nova Scotia

If this process (the Task Force and subsequent government action) should result in a (limited) policy to ban AIDS infected persons from the school system, will this not establish a precedent which will result in schools only being in the first place in a long list of names of banned public places where an AIDS threat is perceived? What will the eventual result be? Will it be to ban such persons from all contact with the rest of our society? Will it commit them to an AIDS colony in some remote location or on an island somewhere? Where is the often referred to "compassion" of a result such as this?

Robert W. Grovestine, Shelburne

I am concerned with the emphasis on confidentiality afforded the HIV carriers. In some instances this protection may be at the expense of public safety. Unfortunately, not all carriers are responsible citizens willing to take the precautions recommended to prevent the spread of the disease.

Sylvia Henshaw, Berwick

In our J.U.S.T. WOMEN group, we are all mothers of school children and as such, we would like this commission to know that we would have no concern that any teacher of our children might carry the AIDS virus.

J.U.S.T. WOMEN, New Glasgow

The Evangelical Lutheran Church in Canada is working to prepare clergy and all its leaders to respond compassionately to those who suffer from the AIDS crisis. Our Church desires to help congregation members better understand AIDS so they can serve as a caring community and to continue to include AIDS sufferers in the life of the community rather than ostracize them because of fear. . . . As the AIDS disease will not simply go away people clearly need more education. People must understand that AIDS is *not* God's punishment against a particular group of people. Rather AIDS is caused by a virus and that virus is not selective: potentially, anyone could be infected.

Rev. Allie Leitzel, Bridgewater

If sexual orientation were added to the Nova Scotia Human Rights Act, discrimination would not end, obviously, but at least it would give us a basis for fighting it. Right now, we have nothing to stand on in Nova Scotia legislation.

Lesbian and Gay Rights

I am a youth worker in my church, working with High School students. On Sunday past I mentioned this meeting and encouraged the members to attend. The discussion that followed was very enlightening. One member made the statement that, "We don't believe the myths and false information, but adults do."

Ed MacIntosh, Stellarton

We know enough about the disease, and how it is transmitted, to protect ourselves from it without resorting to mandatory testing or enforced quarantine

Monica MacLean, Student, Acadia University

We must reduce the level of fear, bringing the debate from the emotional to the rational. There is no question that AIDS is a very serious issue, but we should not be using or accepting words like "epidemic" or "plague".

The Medical Society of Nova Scotia

I would like to draw your attention to a serious threat to public health, one that is related to AIDS but that has not, in my mind, received enough attention from government. That threat is a disease called Public Anxiety Nourished by Irresponsible Coverage, also known by its acronym, PANIC. . . . As its name suggests, PANIC is often spread by contact with the news media, who act as carriers of the disease. These media deal with the truth in a promiscuous and casual fashion. This brings them into frequent contact with distortions, misconceptions and outright lies. Once these untruths enter the body of an infected newspaper or radio station, they multiply a thousand-fold and are passed on to infect the general public. Infected newspapers are often identified by visible symptoms, such as abnormally large, swollen typefaces and blotchy red headlines.

Robin Metcalfe, Halifax

It is hard to verbalize for you the levels of frustration, of alienation and the sheer exhaustions felt by us over the past two years as we have struggled to educate, to support and to try and stem the rising tide of anti-gay sentiment which would inevitably translate into prejudice and discrimination, not only against those affected by AIDS but against all homosexual men and women. . . . We have been working by ourselves too long. We now want to be part of a larger team. We want proper recognition for the contribution we have made and continue to make. We want adequate long-term core funding which will provide us with the stability to do proper strategic planning for the years ahead. Our energies must be focussed on programs and services rather than on writing grant proposals and the continual hiring and training of short-term staff. We also want to prevent the burnout of our most dedicated volunteers. . . . Educational efforts must avoid being too clinical. People are responding primarily in an emotional manner to AIDS; we must use this kind of response to our advantage by appealing to the feeling, caring side of people; by encouraging them to imagine themselves in the other person's shoes. PWAs and persons HIV+ who have the courage to publicly get involved in educational efforts are a tremendous resource. A hundred pamphlets or videos cannot take the place of listening and talking to someone with AIDS for just 15 or 20 minutes. I would like to publicly commend Eric Smith for the contribution he has made, and continues to make, at the price of a tremendous amount of stress, disruptions and loss of privacy in his own life. . . . We would like to commend those medical professionals who have become expert in the care of AIDS patients during the last four years. Unfortunately, the numbers of such professionals remain relatively small and centered in the Halifax area. While this concentration of expertise has been inevitable, to a certain extent, it has placed undue stress on the medical professionals involved, as well as those patients from outlying areas who must travel considerable distances on a regular basis. We therefore feel that every effort should be made to encourage regional centres to increase their expertise regarding the

diagnosis and treatment of PWA/HIV+s. We would also like to encourage an educational program aimed specially at general practitioners.

Metro Area Committee on AIDS

It is to be understood that the on-going tenaciously held goal of the homosexual movement is the acceptance of homosexual acts as a normal variant of human behavior and of homosexuality as an alternative life style. This is totally at variance with traditional understanding of what a family is as defined by the Scriptures and history of our race as we know it. Homosexuality is not an innocent and proper alternative as an accepted life style as has been demonstrated for quite some time.... The scare of an atomic warfare is a very small danger when compared to what AIDS can do to the human community.

Dr. William J. Moorehead, Bible Baptist Church, Greenwood Village

It is clear that AIDS can no longer be seen as a "gay man's disease". It is a disease that could affect any of us. In Nova Scotia, women most at risk are those whose partners are bisexual. In a climate where bisexual and homosexual persons cannot freely express their sexuality, these persons are frequently forced to lead "hidden" lives. Now, more than ever, we need to talk openly about sex and to communicate honestly with those we are intimate with. For many of us, this is not always an easy thing to do.... The high rates of teenage pregnancy and all sexually transmitted diseases and the continuing persecution of those who practice or choose a sexual orientation that differs from the monogamous heterosexual marriage, are all evidence of the lack of accurate, comprehensive sex education that characterizes Nova Scotia and Canada in general.... We believe that two of the main causes of unintended teen pregnancy and sexually transmitted diseases are sexual ignorance and misinformation. And furthermore, we believe that individuals who are given accurate information about sexuality tend to behave more responsibly.... In 1986, a local Planned Parenthood survey found that 85% of respondents felt that there was a need for sexuality education in the community. A 1984 Gallup poll revealed that 83% of Canadian adults believe sex education should be taught in schools. While we frequently hear from vocal individuals who oppose sex education in the schools, we firmly believe that these individuals represent only a small minority of Nova Scotians.

Nova Scotia Advisory Council on the Status of Women

The AIDS crisis is raising many ethical issues for all of us. We need to examine as a society how we value all of our members; how we treat the weaker ones; how we serve the suffering; how we regard minorities, including those of different sexual orientation; how we provide for the necessary protection of our own and how we educate for the well-being of all; how we understand our own mortality; and how compassionate we are as a people.... We insist that the right of confidentiality be maintained for those who are diagnosed as having AIDS or as carriers of the AIDS virus, unless there becomes some immediate provable medical reason to share that information.... We believe that an emphasis on palliative care is one that needs to be encouraged, as well as support services for families and loved ones who are experiencing emotional, economic and social hardships during this period. We think especially where the patient is a child or an adolescent that there are heavy costs borne by the family which may have to be supplemented in order that all members of the family will not suffer.

The Right Reverend A.G. Peters
Bishop of the Anglican Diocese of Nova Scotia

We would recommend the establishment of a central clearing house in Nova Scotia for information on AIDS that is readily available and current. As well, we would like to see the establishment of a list of speakers who would be available to speak on very specific issues related to various aspects of AIDS.

Pictou County Medical Society

Education is the only way to prevent the spread of AIDS. This has been demonstrated in the gay population in the US where the rates of new infections are being reduced. We therefore recommend that AIDS education of adolescents be part of a comprehensive sexuality education. Promotion of abstinence is not sex education.

Pictou County Women's Centre

We know that the greater number of people with AIDS comes from the gay male population. Nova Scotia does not provide protection of gay and lesbian people. We cannot protect people with AIDS as long as discrimination on the basis of sexual orientation is permitted. . . . Just as people with AIDS cannot be protected in a community in which their fundamental rights are denied, neither can the largest number of those with AIDS be dealt with humanely when attitudes such as homophobia go unchallenged. This atmosphere of condemnation must be addressed or other efforts to provide care for citizens with or exposed to AIDS will be futile.

Brenda K. Richard, Associate Professor
Maritime School of Social Work, Dalhousie University

The goal of AIDS education should be the prevention of the disease and the reduction of misinformation. The government must be careful not to enact AIDS-control laws that are a response to misconceptions about the transmission of the AIDS virus. AIDS is a public health issue and not a morality issue. . . . If 76% of all sexually-transmitted disease cases involve people under 24, it should be obvious that young people are sexually- active. They need clear, unbiased accessible information about responsible sexuality and safer sexual practices, and they need to be able to acquire such things as latex condoms and spermicide without embarrassment. Providing such items to school-age children may or may not encourage immorality. Not providing them does lead to death.

Second Story Women's Centre, Bridgewater

We see no reason for any form of discrimination against either the AIDS victim or a person testing AIDS positive. There seems to be no rational basis for discrimination in schools, universities or in the workplace. Any form of discrimination can only serve to increase the sense of isolation and the pain of the AIDS infected person. Discrimination is not only medically unnecessary, it is contrary to the spirit of Christianity and treats persons as less than human.

The Shelburne County Ministerial Association

Make sure the education in the school does not side step the moral and ethical issues. When will we get back to teaching that there should be no sex before and outside of marriage? I know this is a bit much to ask. Certainly it needs to be presented as one of the best ways to make sure one does not get AIDS. At Halifax Christian Academy we teach that marriage is honourable in all and the bed undefiled: but whoremongers and adulterers God will judge.

Reverend Roland L. Smith D.D.

University students have to make serious decisions about themselves as sexual beings and they need access to the most accurate information possible to assist them in these decisions. . . . There is no coy way to educate on these matters. If AIDS education is to be effective it must be realistic and it must be prepared to use descriptive terms. The assumption that a statement like "AIDS is a sexually-transmitted disease" actually educates is a dangerously false one.

Students Union of Nova Scotia

Because I am a parent, it is my right to make decisions about my children until my children are mature enough or old enough to make decisions for themselves. I am responsible for that child – not the School Board or the teacher . . . . We have sought medical advice, we have spent a lot of money, time and energy to gather all the facts and information we could, and in light of these facts as they now stand, we do not feel we can place our children in this risk, and we will not subject our children to a virus disease that could kill them. After all, why would you send your child to school with an unhealthy teacher when there are healthy teachers available? . . . Parents have to live with any and all decisions made and how they affect their children. If indeed we live in a democratic society, then the message is clear. The vast majority feel there is too much at stake and the risk is too great to have AIDS carriers teaching our children.

Linda Swim, United Concerned Parents of Cape Sable Island

Workers with a continuing chronically infective condition (such as HIV-positivity) should be barred from direct hand-to-patient contact, but should receive fully compensated job retraining and family support for further employment. . . . Continuing chronically infective conditions (including HIV) testing should be mandatory in doctors, nurses, laboratory technologists who collect blood, teachers, school cafeteria workers, school bus drivers, certain public transportation workers, all military personnel, and certain other groups designated by public health officials (usually the Minister of Health). All hospital admissions should be automatically tested for certain infectious conditions, including HIV.

William Thurlow, M.D., Digby

We must remember that we are dealing with a contagious disease that has definite limitations as to how it can be spread and, that once one is aware of these limitations, the disease becomes manageable. One of the problems in dealing with AIDS is that some groups of people do not appear to be listening to what is being said by those people who have current knowledge of the virus. Instead, it appears as if some people are using the fear of AIDS to support their own personal vendetta against homosexuality. . . . The key to this whole program appears to be more accurate and sustained public information programs to allay the anxiety and dispel the myths that have grown up around this illness. This information program must come from a provincial level in order to provide consistency and a voice of authority.

Donald V. Wright, M.D., Chester Board of Health

Costing of Recommendations

Since it was part of the mandate of the Task Force to consider the cost implications of at least those recommendations dealing specifically with the care and treatment of persons with AIDS, the Task Force was mindful throughout its deliberations of the potential financial cost of various of the recommendations it wished to make. In fact, most of the recommendations presented in this report will involve some level of budgetary expenditure for the government of Nova Scotia.

There are three categories of cost associated with AIDS:

- *proactive direct costs* – direct costs incurred in programs/policies intended to prevent transmission of the disease and to control its incidence. Examples of such costs would include public education programs, counselling services for homosexuals, research, etc.

- *reactive direct costs* – direct costs incurred in responding to the needs of persons already affected. Examples of such costs would include inpatient and outpatient medical care, home care services, blood testing and laboratory services, etc.

- *indirect costs* – the value of output lost to society from HIV-positive persons or PWAs due to illness or death.

Available studies from the United States indicate that the indirect costs are in the order of six to eight times larger than the direct costs. Yet these indirect costs do not directly have any budgetary implications for government. Reactive direct costs include the care and treatment costs the Task Force was asked to analyze as part of its mandate. Although subject to general financial and resource constraints on the overall health care system, on an individual patient basis, once the patient is accepted for treatment, these costs are, to a large degree, non-discretionary. Proactive direct costs, by contrast, are highly discretionary. Yet, as will be argued below in greater detail, there may be a direct trade-off between proactive program expenditures and reactive treatment expenditures.

The recent study on AIDS by the Royal Society of Canada (AIDS: A Perspective for Canadians, April 1988) estimated that the annual cost of treating a person with AIDS is at least $82,410 a year. If we assume this figure also holds true for Nova Scotia, the direct cost to government for treatment of PWAs, based on 18 known PWAs as of April 1988, is $1,483,380 per year as of 1988. If we were to assume 200 surviving PWAs by 1992, the cost would rise to $16,482,000 per year (in 1988 dollars). The figure of 200 persons with AIDS by 1992 is wholly arbitrary and used purely for illustration purposes.

The real significance of these numbers, however, lies in looking at them from a different perspective. If an AIDS patient costs at least $82,410 per year for treatment, then it is worth spending up to this amount to prevent the spread of AIDS to one additional person. By extension, if public education, counselling, etc. can prevent the spread of the disease to an extra 20 persons, then it is worth spending up to $1,648,200 on such proactive programs. These figures, moreover, are minimum estimates, not only because the figure of $82,410 per patient-year is a minimum but because the indirect costs of foregone output by PWAs is not provided for in these numbers. If we accept the U.S. estimate that the indirect costs are at least six times larger than the direct costs, then proactive programming that prevents the spread of the disease to 20 additional persons would provide a saving to society of at least $11,537,400. In other words, proactive programming involving an $11-12 million expenditure per annum would pay for itself, in terms of its social benefit or return, if it reduced the incidence of the disease by 20 persons. This, moreover, makes no allowance for the personal cost to AIDS victims and their families and relatives which coping with the disease can involve. If more than 20 persons were prevented from contracting the disease by such a program,

there would actually be a net saving or net benefit to society when both the direct and indirect costs are taken into account.

The Royal Society report also makes a number of recommendations regarding costs, including the following:

> That a prospective study of newly diagnosed persons for a predetermined period of time be done given that very little is known to date on the cost of AIDS and HIV-infection in Canada. The direct costs of treating HIV-infections are greatly varied and almost nothing is known to date about any costs other than those that are incurred in the hospital setting. More information is needed on those costs incurred outside the hospital, such as the costs of home care, hospice care, physicians' services, drug costs, social assistance and disability insurance. (R. Fraser and M. Cox, "The Economic Impact of AIDS in Canada," in Royal Society of Canada, *AIDS: A Perspective for Canadians*, Background Papers, (Ottawa: The Royal Society of Canada, 1988), p. 171).

Two points are significant about this quotation. First, it highlights a number of the problems regarding the lack of data for estimating costs and the uncertainty which surrounds those numbers we do have. Second, assuming the federal government pays heed to the Royal Society report and specifically to the recommendations for costing studies, Nova Scotia can hope to benefit from this work once it has been carried out.

The Task Force did not undertake any original studies of the cost of the care and treatment of PWAs in Nova Scotia. This was due both to the types of problems referred to in the quotation from the background paper of the Royal Society Report and to the lack of time and resources available to the Task Force, given these problems, to carry out such a study properly. More specifically, the Task Force identified the following problems which a proper costing study would have faced:

- First, certain of the recommendations involve programs or actions which may be as large or small as government wishes or is prepared to make them. The recommended public education campaign, for example, is impossible to cost unless one is prepared to define the scale of the program in the first place. But the scale of the program will be determined, in turn, by the amount of money which government is prepared to put into the program. The argument becomes a circular one with no unique solution unless one of the variables is taken as a given.

- Second, the cost of programs will not necessarily be borne entirely by government. Support for voluntary agency work, for example, does not mean full funding for such agencies. But neither is there any way, *a priori*, to define the minimum contribution called for. There is too much uncertainty regarding levels of public financial support for such agencies as well as the scale and scope of the role such agencies might be asked to play to attempt to answer these questions on the part of the Task Force. Nor was it deemed appropriate for the Task Force to seek to pre-empt the process of negotiation between such agencies and government regarding these matters.

- Third, insofar as the Task Force has sought to impress the principle that health and care services for PWAs should be provided within the context of existing health care programs and policies, it was(is) not clear what the relevant costs of providing care to AIDS victims would be. Full cost measures would be misleading insofar as the basic infrastructure support is already in place as are many of the health care personnel who will be involved in the treatment of PWAs. Incremental costs, on the other hand, may be equally misleading if the system adapts to the treatment and care of PWAs by cutting back or delaying treatment and care of other non-AIDS conditions. In this case, the financial or budgetary cost to government may be nil. Cost numbers, in and of themselves, will have no special meaning. Alternatively, if the provision of care for PWAs leads to the creation of special facilities, then full cost, not incremental cost, is

relevant. And so the argument turns in on itself. The principle that PWAs must have access to appropriate care is not made any stronger or served any better by attempting to cost the financial implications for government because the assumptions that must be made to arrive at any set of estimates would be entirely arbitrary.

- Fourth, even if the problems just noted are assumed away, there would remain a major uncertainty regarding both the number of patients to be considered as well as the nature and duration of their care needs. Knowing the cost per patient per day of, for example, hospital care or home care has little meaning for government in assessing its budgetary commitments if it doesn't also know the number of persons and the number of days involved. Epidemiological projections for the incidence of the disease in Nova Scotia are fraught with uncertainty. But even if they could be accurately determined, we still wouldn't know, based on current available evidence, how long a treatment period any particular patient might require or the nature of the treatment. AIDS as a disease manifests itself in the occurrence of other illnesses. Each of these may vary from one patient to another and be of different duration and frequency. Cost numbers based on some "average" patient, with a set of "typical" symptoms lasting some "average" time have little significance.

- Fifth, to estimate costs within a given institutional framework locks one into the assumptions which go with that framework, even though those assumptions may not be the most appropriate for the particular circumstances of AIDS. For example, to estimate the cost of treatment based on the cost of a hospital bed per day assumes that hospitalization is the best method for providing treatment. In fact, home care or hospice care may be more appropriate to meeting patient needs. Some people take the argument a step further and maintain that costs will be minimized if there is a surplus of hospital beds into which PWAs can be placed. Such an argument, however, not only overlooks the incremental cost of an occupied bed but makes the mistake of taking the number of available beds as a given. In other words, it locks in the assumptions of the existing institutional setting. If we allow the number of beds to become variable, then true cost minimization may call for reducing the number of beds and providing alternative forms of service delivery. In other words, the local cost is not necessarily the same as the global cost minimum (number of beds variable). This is an important point but one which, pursued properly, would have extended the Task Force well beyond its mandate. It is an issue which, in general, the Task Force expects will be examined by the Nova Scotia Royal Commission on Health Care.

- Sixth, there is a lack of available data on costs of representative health care programs to use as a basis for projecting the costs of many of the Task Force's recommendations. This problem could only have been overcome by the Task Force by devoting considerable resources, both in time and money, to carrying out detailed research into these questions. Apart from whether either the time or money was available, the benefits of such an exercise were felt to be in question for all of the preceding reasons.

- Finally, in certain cases, the issue of funding will be a matter of negotiation between government and hospitals, health care professionals and/or other agencies/individuals/ associations. To provide cost estimates for such recommendations would, like the earlier example of funding for voluntary agencies, pre-empt such negotiations.

Having said all this, the Task Force did examine such cost figures as those reported earlier from the Royal Society Report. Also, the Task Force was guided in its recommendations by three basic points of principle:

- First, one of the primary purposes of the Task Force was to offer advice to government on policy decisions that might be taken in responding appropriately and compassionately to the many problems surrounding AIDS. Implicitly, the Task Force's recommendations reflect the sense

on the part of Task Force members that the called-for actions stemming from these recommendations are necessary if this province is to respond in such a manner. In other words, there is a type of cost-benefit analysis implicit in the recommendations, based on the subjective sense of Task Force members of relative benefits versus costs. Except in those few cases where it is noted that certain recommendations may require further consideration, no recommendation that did not meet this implicit cost-benefit test has been put forward.

- Second, where the Task Force perceived that there were possible alternative policies that could achieve the same result, the cheaper option, as long as it was felt to be relatively as effective, has been recommended. Thus, for example, rather than recommending a new (and potentially costly) AIDS education curriculum in the public school system, the Task Force has endorsed the Department of Education's Personal Development and Relationships program for Grades 7 to 9 as part of the recommendation that AIDS-specific education be compulsory for all students from at least Grade 7 to Grade 12. As another example, it has been recommended that health and care services be provided within the context of the existing health care program and policies and that home care be coordinated through the new, recently announced provincial home care program. These recommendations are justified on a number of grounds, most notably the desire to treat AIDS like other diseases from a care perspective. But they also have the virtue of minimizing costs by not duplicating (expensive) overhead and administrative charges such as would accompany unique, dedicated care programs for AIDS sufferers.

- Third, while the Task Force recognizes both the general fiscal constraint under which the government of the province is operating and the vast number of competing demands on scarce provincial resources, necessitating some process for determining the fiscal priorities of government, the Task Force also felt that it was beyond the scope of its mandate to comment on overall government fiscal policy. Inevitably any greater provision of cost data would have coloured the Task Force's own priorities with respect to its recommendations on dealing with the specific issue of AIDS and might have given the appearance of a *de facto* ranking of the policy recommendations based on their cost.

The Task Force realizes that government must make some difficult fiscal decisions based on little objective evidence regarding costs. But it should bear in mind the very important point made earlier that successful proactive programming will yield a direct dollar return in terms of savings on reactive direct treatment costs. Because proactive costs are somewhat discretionary in terms of deciding how much to spend, while reactive costs are to some extent unavoidable, there may be an understandable tendency on the part of government to hold back on the proactive side. To do so, however, would be a false economy.

Compared to many other diseases, the present and prospective direct costs of care and tratment for PWAs is relatively small. For example, in 1987, there were 2,300 new cases of cancer diagnosed in Nova Scotia compared with 15 new cases of AIDS; the cost of care and treatment of each cancer patient would be no less per year, and perhaps more, than each AIDS patient. The point of this example is not to invite unwarranted rankings of disease according to cost per patient year. Rather it is to stress that the cost of AIDS treatment is still relatively small. By implementing appropriate proactive programs, i.e., by approving expenditures aimed at prevention and containment of the disease, the government of Nova Scotia may be able to insure that this remains the case. Such action will not only meet the long-term fiscal needs of the government but, more importantly, will spare individuals the personal and financial tragedy of AIDS. While the incidence of the disease is still low, government has a unique opportunity, one not enjoyed with other diseases, to act in a positive way to keep it low. Expenditures for such programs should not be seen as a cost but, rather, as a benefit.

May 19, 1988

NOVA SCOTIA TASK FORCE ON AIDS

INTERIM RECOMMENDATIONS

Introduction

After extensively reviewing AIDS public information and education efforts, both within and outside Canada, it is the considered opinion of the Nova Scotia Task Force on AIDS that the best method presently available to control the spread of HIV infection is through a comprehensive public education program. Our objective in proposing the interim recommendations that follow is to reinforce and broaden existing efforts and to ensure that consistent information is disseminated on an ongoing basis.

To date, the most effective approach for creating a sound public information and education effort involves a comprehensive strategy directed at increasing, then maintaining awareness and knowledge levels within the general population and encouraging attitude and behaviour change within specific subgroups of the population.

It is recommended that Nova Scotia initiate a co-ordinated, comprehensive program of community-based public education. The goals of a public education program for AIDS in Nova Scotia are to:

i) increase the public's understanding of HIV infection and AIDS;

ii) prevent the spread of HIV infection; and

iii) develop a caring and compassionate community response to AIDS.

The Task Force has identified several mechanisms for meeting these goals. The following interim recommendations address primarily the goal of increasing knowledge and understanding regarding AIDS. This is an essential basis for containing the spread of infection and for developing an appropriate community response to AIDS. Additional recommendations that address this and other goals will be contained in the final report of the Task Force.

The following two considerations apply to all the interim recommendations:

i) AIDS education programs or activities initiated pursuant to the recommendations should undergo formative and outcome evaluation and be revised as necessary.

ii) The costs associated with the following recommendations have not been determined as these will depend on the implementation strategy. It should be noted, however, that some government departments have already started working on the implementation of certain recommendations.

IT IS RECOMMENDED THAT:

I. Comprehensive Public Education

1. **A provincial multi-media (TV, radio, posters, pamphlets, etc.) campaign aimed at the general population to increase awareness and knowledge about AIDS be developed and implemented.**

2. **A follow-up (albeit reduced) multi-media campaign to maintain the knowledge levels of the general population and reinforce the messages regarding how to prevent AIDS transmission be developed and implemented.**

3. **An AIDS public information committee be established under the aegis of the permanent AIDS Advisory Commission, with representation from the media and the government, to develop and implement a co-ordinated and on-going mass-media campaign.**

These recommendations will require further elaboration in order to reach all audiences and address the specific needs of identified audiences. To this end, it will be recommended that a series of targetted initiatives be developed and implemented with the goal of trying to change attitudes and behaviours.

Such audiences could include:

i) audiences at high risk of contracting the AIDS virus.

ii) audiences with special needs that can best be served through specialized campaigns.

iii) audiences that have specific concerns that are best addressed through focussed attention.

To fulfill this aim, further research and deliberation is needed before detailed strategy options designed for the specific target audiences can be developed.

II. Public Schools

4. **The Department of Education require that AIDS-specific information be compulsory for all students beginning at least in Grade 7 and continuing until Grade 12.**

In support of this recommendation, the Nova Scotia Task Force on AIDS:

i) endorses the Department of Education's Personal Development and Relationships program including AIDS education, which is designed for students in Grades 7 to 9; and

ii) endorses the Department of Education's resources and guidelines for senior high schools and urges that all senior high school students receive appropriate AIDS education, as approved by the Department of Education, in addition to AIDS information received in any existing courses.

Rationale: It is necessary that our young people receive the appropriate educational material to be able to protect themselves against AIDS.

Objective: All students receive appropriate information regarding AIDS and the transmission of the virus and how to prevent contracting the AIDS virus.

5. **All elementary teachers be provided with in-service training that will enable them to respond in an age-appropriate manner to AIDS-related issues and questions.**

Rationale: In order that students receive age-appropriate AIDS information, elementary teachers must be prepared to deal with AIDS-related questions and issues.

Objective: Teachers be able to respond to AIDS-related questions and issues.

6. **Teachers in the public schools and community colleges be provided with appropriate in-service programs in AIDS education, including basic knowledge, updating on developed curriculum materials, and age-appropriate methods for teaching and dealing with AIDS-related issues and questions.**

Rationale: In order that students receive appropriate AIDS information in a non-threatening environment, teachers must be prepared to deal with the AIDS-related content and the psycho-social issues and questions related to this area.

Objective: Teachers be able to teach and respond to AIDS-related issues and questions.

7. **School boards provide parents with an opportunity to review and become familiar with the instructional materials to be used in the schools within a structured parent-teacher environment.**

Rationale: To provide parents with information about the AIDS curriculum their children are receiving.

Objective: Parents have the opportunity to be knowledgeable about the AIDS curriculum offered in the schools.

III. Post Secondary Educational Institutions

8. **The Department of Advanced Education and Job Training develop and require that annual AIDS-specific education be compulsory for students in institutions under its jurisdiction.**

Rationale: It is necessary that our young people receive the appropriate educational material to be able to protect themselves against AIDS.

Objective: All community college students receive appropriate information regarding AIDS and the transmission of the virus and how to prevent contracting the AIDS virus.

9. **Universities (including Dalhousie, Mount St. Vincent, N. S. College of Art and Design, St. Francis Xavier, King's College, Acadia, Saint Mary's, Technical University, Université Ste. Anne, University College of Cape Breton, Atlantic School of Theology, N. S. Agricultural College, and N. S. Teachers College) assume responsibility for developing an educational program which will ensure that all students receive consistent and reliable AIDS information on an on-going basis. Where appropriate, consultation and advice can be provided through the Department of Health and Fitness, the Department of Advanced Education and Job Training, and other knowledgeable agencies.**

Rationale: It is necessary that university students receive consistent and reliable information to be able to protect themselves against AIDS.

Objective: To ensure that university students are provided with AIDS information and education on an on-going basis.

10. **Institutions that have students in training for teaching and health and care occupations ensure these students be provided with appropriate AIDS education within their curricula. Where appropriate, consultation and advice can be provided through the Department of Health and Fitness, Department of Education, and other knowledgeable agencies.**

Rationale: These students need to receive appropriate AIDS-related information necessary to their functioning in their chosen professions.

Objective: To ensure that students in training receive appropriate AIDS-related information.

IV. Other Information Programs

Hotlines

11. **All existing helpline/hotline personnel (not specifically AIDS-related) receive education on AIDS and the issues surrounding AIDS.**

Rationale: To ensure consistent and reliable information relating to AIDS is delivered in the community by existing structures.

Objective: To ensure that all helpline/hotline personnel can address questions, concerns, and requests they may receive in regard to AIDS.

12. **A province-wide, toll-free AIDS hotline be established to provide information and referrals to all Nova Scotians on an anonymous basis.**

Rationale: A hotline can provide anonymous, individualized information to people who might not otherwise seek these services in their own communities or where such services might not be available.

Objective: To provide reliable and consistent AIDS information and referrals for counselling or treatment on an anonymous basis.

Workplace

13. **An AIDS education program be provided for public and private sector employees and employers. Where possible, existing programs should be used.**

Rationale: To have in place a base of knowledge about AIDS to provide consistent and reliable information in order to avoid or reduce unnecessary anxiety and discrimination.

Objective: To educate all employees and employers regarding basic knowledge about AIDS, including transmission of the AIDS virus, possible occupation-specific exposure to the virus, appropriate infection control procedures, and discrimination.

Note: In development of arrangements for this program, it is important that employee unions and organizations, as well as employers, be involved.

On behalf of the Nova Scotia Task Force on AIDS,

W. Andrew MacKay
Chair

May 19, 1988

Department of
Education

Office of the Minister

PO Box 578
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B3J 2S9

STATEMENT . . .

MR. SPEAKER, HONOURABLE MEMBERS:

THE NOVA SCOTIA TASK FORCE ON AIDS, THAT HAS RECENTLY COMPLETED THE FIRST PHASE OF ITS ACTIVITIES, HAS REACHED CONSENSUS ON A NUMBER OF AREAS IN WHICH IT RECOMMENDS GOVERNMENT ACTION IN THE NEAR FUTURE.

IN ITS INTERIM REPORT, THE TASK FORCE VIEWS PUBLIC EDUCATION AND PUBLIC SCHOOL EDUCATION AS BEING OF THE FIRST IMPORTANCE.

IN THE LIGHT OF MY OWN RESPONSIBILITY FOR PUBLIC SCHOOL EDUCATION, I AM TODAY PLEASED TO OUTLINE FOR THE INFORMATION OF THIS HOUSE, CERTAIN MEASURES THAT THE DEPARTMENT OF EDUCATION WILL TAKE IN RESPONSE TO THESE INTERIM RECOMMENDATIONS:

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(1) WITH REGARD TO THE RECOMMENDED PROVISION OF IN-SERVICE TRAINING FOR ALL ELEMENTARY TEACHERS, THE DEPARTMENT WILL ASSIST EACH SCHOOL BOARD TO TRAIN AN IN-SERVICE TRAINING TEAM THAT WILL IN TURN PROVIDE THE APPROPRIATE IN-SERVICE ON AIDS-RELATED ISSUES AND QUESTIONS TO ALL THE ELEMENTARY TEACHERS WITHIN ITS JURISDICTION.

(2) WITH RESPECT TO MAKING AIDS-SPECIFIC INFORMATION COMPULSORY FOR GRADE 7-12 STUDENTS, THE DEPARTMENT WILL REQUIRE ALL SCHOOL BOARDS TO MAKE AIDS EDUCATION COMPULSORY FOR ALL STUDENTS IN GRADES 7-12 BEGINNING IN THE SCHOOL YEAR 1988-89.

I APPRECIATE THE COMMITTEE'S ENDORSEMENT OF EFFORTS ALREADY BEING MADE TO INFORM YOUNG PEOPLE THROUGH OUR NEW PERSONAL DEVELOPMENT AND RELATIONSHIPS PROGRAM (PDR) FOR GRADES 7-9, AND I AM ALSO PLEASED TO SAY THAT THE PDR PROGRAM WILL BE PHASED IN AS A

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COMPULSORY COMPONENT OF JUNIOR HIGH EDUCATION. THE AIDS-RELATED SECTION OF THIS PROGRAM WILL BE COMPULSORY FOR ALL STUDENTS BEGINNING IN SEPTEMBER, 1988.

MY DEPARTMENT HAS ALREADY BEEN PROVIDING SCHOOL BOARDS WITH AIDS EDUCATION INFORMATION AND RESOURCES FOR THE SENIOR HIGH LEVELS. I AM NOW PREPARED TO REQUIRE ALL SCHOOL BOARDS TO OFFER AN AIDS EDUCATION SEGMENT DURING THE SCHOOL YEAR TO STUDENTS IN GRADES 10-12, USING THESE RESOURCES. SEVERAL FORMATS ARE DESCRIBED IN THE ACCOMPANYING TEACHER MATERIALS, SO THAT THIS MAY BE FITTED INTO THE HIGH SCHOOL PROGRAM AS SUITABLE.

IN ALL OF THE ABOVE COMPULSORY INITIATIVES, I WISH TO CONFIRM THAT PARENTS WILL IN ALL CASES HAVE THE RIGHT TO ELECT THAT THEIR CHILDREN NOT PARTICIPATE IN ALL OR ANY ASPECTS OF THIS COMPULSORY PROGRAM.

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(3) WITH RESPECT TO THE RECOMMENDED IN-SERVICE FOR JUNIOR AND SENIOR HIGH SCHOOL TEACHERS, THE DEPARTMENT WILL AGAIN BEGIN TRAINING TEAMS OF TEACHERS FROM EACH SCHOOL BOARD IN MAJOR SESSIONS PLANNED FOR THE FALL OF 1988. THESE TEAMS WILL IN TURN HELP TRAIN THEIR COLLEAGUES IN THEIR RESPECTIVE BOARDS. THE DEPARTMENT WILL CONTINUE TO PROVIDE SUPPORT AND ASSISTANCE FOR THESE LOCAL BOARD IN-SERVICES.

IF I MAY, I WOULD ALSO LIKE TO ADD A WORD ON PRE-SERVICE TRAINING OF TEACHERS. AT NOVA SCOTIA TEACHERS COLLEGE, THE PRINCIPAL, HEALTH EDUCATOR, THE SCHOOL NURSE, AND THE DIRECTOR OF STUDENT SERVICES EACH APPEARED INDIVIDUALLY BEFORE THE AIDS TASK FORCE TO EMPHASIZE THE NEED FOR PRE-SERVICE PROVISIONS FOR TEACHERS-IN-TRAINING. NSTC ALREADY REQUIRES THAT ALL STUDENTS TAKE AT LEAST ONE HEALTH EDUCATION COURSE. IN ADDITION ALL STUDENTS AT THE NOVA SCOTIA TEACHERS COLLEGE ARE NOW BEING PREPARED TO DELIVER AIDS EDUCATION APPROPRIATE TO THE LEVEL AT WHICH THEY EXPECT TO TEACH.

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THROUGHOUT THIS PRE-SERVICE PERIOD, THE EMPHASIS IS ALWAYS ON THE TREMENDOUS RESPONSIBILITY THEY WILL HAVE TO THEIR YOUNG CHARGES, INCLUDING THE POWER OF EXAMPLE AND THE IMPORTANCE OF THE MOST SENSITIVE HANDLING OF SEXUALITY AND RELATED MATTERS. HUMAN RESPECT AND DIGNITY ARE TO BE ALWAYS CENTRAL TO SUCH DISCUSSIONS AT ALL TIMES.

(4) THIS BRINGS ME TO THE MATTER OF INFORMING PARENTS OF THESE DEVELOPMENTS. IN THAT RESPECT, I WILL REQUIRE THAT ALL SCHOOL BOARDS ESTABLISH A POLICY RELATED TO PARENTAL INVOLVEMENT AND INFORMATION ABOUT AIDS EDUCATION. THIS MIGHT TAKE THE FORM OF PARENTS' NIGHTS, OR OTHER TIMES AND ARRANGEMENTS FOR PARENTS TO REVIEW AND BECOME FAMILIAR WITH THE INSTRUCTIONAL MATERIALS WITHIN A STRUCTURED PARENT-TEACHER ENVIRONMENT, AS RECOMMENDED BY THE AIDS TASK FORCE.

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IN SUMMARY, I BELIEVE THAT THE PLAN OF ACTION THAT I HAVE DESCRIBED WILL ASSIST PUBLIC SCHOOL TEACHERS AND STUDENTS, WITH THEIR PARENTS, TO BECOME KNOWLEDGEABLE ABOUT AIDS, AS A MEANS OF PREVENTING ITS SPREAD WITHIN OUR COMMUNITY, AND IN ACCORDANCE WITH THOSE OBJECTIVES OF THE AIDS TASK FORCE, WHICH HAVE BEEN ADOPTED BY OUR GOVERNMENT.

-END-

HON. RON GIFFIN, Q.C.

MAY 20, 1988

PROVINCE OF NOVA SCOTIA

Response to Recommendations of the Nova Scotia Task Force on Aids

Department of Advanced Education
and Job Training

Honourable Edmund L. Morris
Minister

July 25, 1988

DEPARTMENT OF ADVANCED EDUCATION
AND JOB TRAINING

Response to Recommendations of the
Nova Scotia Task Force on AIDS

1. The Department of Advanced Education and Job Training accepts the interim recommendations of the provincial Task Force on AIDS which bear upon the Department's jurisdiction and responsibility.

2. In cooperation with the Department of Health and Fitness, teachers and students in several Community Colleges have discussed and will continue to discuss issues relating to AIDS with regard to protection on the job, at the work-site and in the Colleges. Conducted by personnel of the Department of Health and Fitness, these workshops ensure that both instructors and students are aware of how to protect themselves against receipt or transmission of AIDS, while also addressing misconceptions about the disease, its transmission, and the dangers it poses.

3. The Department will ensure that all Community College instructors and students are provided with the facts about AIDS and related health issues. To that end, the Department will:

   (a) work with the Department of Health and Fitness to develop in-service material and programs for Community Colleges to provide all instructors with information to maintain safe working and teaching environments for themselves and students;

   (b) work with the Department of Health and Fitness to provide AIDS-specific information and education to all full-time and part-time Community College students. Instruction will be provided by Department of Health and Fitness personnel, in October each year, commencing 1988;

   (c) work with the Department of Health and Fitness to develop AIDS-related information for incorporation into curricula for health and care programs in Community Colleges, and ensure that the information is updated regularly;

   (d) distribute AIDS-specific material and information developed or approved by the Department of Health and Fitness to all Community Colleges staff, and students and ensure that they have access to the latest information on the disease.

(e) through the Nova Scotia Council on Higher Education, request confirmation from post-secondary institutions of the efforts they are making to provide AIDS-related information to their students, faculties and support staffs.

4. The Department will rely on the Department of Health and Fitness for information on AIDS and related health issues and for assistance, on a sustained and continuing basis, in dealing with matters related to AIDS. This close ongoing cooperation will ensure that the Department of Advanced Education and Job Training's instructors and students have access to the latest and most accurate information at all times.

5. Maintenance of accident-free educational and training environments in Community Colleges is of paramount concern to the Department. As the potential for injury to students and instructors, despite the best precautions, does exist in some of the training courses, albeit in the presence of the most current precautions, the Department of Health and Fitness is being asked to conduct workshops at each Community College to ensure that instructors and students are aware of the precautionary measures that should be taken in emergency situations, where first aid must be administered or blood or other bodily fluids removed. The Department's objective through these workshops is to ensure that, on graduation, Community College students can take this important information with them into the workplace, thereby protecting themselves from exposure to AIDS and other blood-borne diseases and assisting in educating their fellow workers.

July 25, 1988

List of Recommendations

AIDS EDUCATION AND INFORMATION

AIDS Education for the General Public

Recommendation 1

Under the aegis of the Nova Scotia Advisory Commission on AIDS:

a) A provincial multi-media campaign aimed at the general population should be developed and implemented in order to increase awareness and knowledge about AIDS.

b) Media campaigns should be co-ordinated by a public information committee which includes representation from the media and government. They should be modelled after those used for the Premier's task force on drinking and driving.

c) Follow-up multi-media campaigns should be developed and implemented to maintain the knowledge levels of the general population and reinforce the messages regarding how to prevent AIDS transmission.

d) AIDS education guides should be made available to community-based service organizations that engage in community education programs.

AIDS Education in the Workplace

Recommendation 2

a) AIDS education programs should be provided for public and private sector employees and employers. Whenever possible, existing programs should be used.

b) Employers should be encouraged to provide, or to permit public health officials to provide, AIDS education programs for the workplace.

AIDS Education for Specific Audiences

Recommendation 3

In order to meet the needs of high-risk, hard-to-reach and special-needs audiences, the Government of Nova Scotia should make available appropriate funding or resources to community-based organizations.

AIDS Hotline

Recommendation 4

A province-wide, toll-free AIDS hotline should be established to provide information and referrals to all Nova Scotians. The hotline should deal with enquiries on an anonymous basis.

Recommendation 5

All personnel of existing hotlines which have not been created to deal with AIDS should receive education on AIDS and the issues surrounding AIDS.

AIDS Education in the Schools

Recommendation 6

The Department of Education should require that AIDS-specific information be a compulsory offering for all students beginning no later than Grade 7 and continuing through Grade 12.

Recommendation 7

a) The Department of Advanced Education and Job Training should develop and require that annual AIDS-specific education be compulsory for students in institutions under its jurisdiction.

b) All universities and colleges in the province should assume responsibility for developing an educational program which will ensure that all students receive consistent and reliable AIDS information on an on-going basis. Where appropriate, consultation and advice should be provided through the Department of Health and Fitness, the Department of Advanced Education and Job Training, and other knowledgeable agencies.

Recommendation 8

a) Teachers in public schools and community colleges should be provided with appropriate in-service programs in AIDS education. The in-service programs must include basic knowledge on AIDS, updating on curriculum materials developed to deal with AIDS, and age-appropriate methods for teaching and dealing with AIDS-related issues and questions.

b) Institutions providing training for teachers, and for those to be engaged in the health and care occupations, should ensure these students are provided with appropriate AIDS education within their curricula. Where appropriate, consultation and advice can be provided through the Department of Health and Fitness, Department of Education, and the Department of Advanced Education and Job Training.

Recommendation 9

All elementary school teachers should be provided with in-service training that will enable them to respond in an appropriate manner to the AIDS-related issues and questions of their students.

Recommendation 10

Within a structured parent-teacher environment, school boards should provide parents with an opportunity to review and become familiar with the instructional materials to be used in the schools.

Ensuring Accurate Information

Recommendation 11

The Nova Scotia Advisory Commission on AIDS should be have responsibility for establishing:

a) a clearinghouse to make available up-to-date information on AIDS.

b) a mechanism to review the accuracy and consistency of educational materials produced under the sponsorship of the Government of Nova Scotia.

c) a mechanism to respond to inaccurate information publicized in the media.

PROVIDING CARE AND FINANCIAL SUPPORT TO HIV-INFECTED PERSONS

General Principles of Care

Recommendation 12

Health and care services should be provided within the context of existing health care programs and policies. Home care services should be co-ordinated through the home care program recently announced by the Government of Nova Scotia.

Hospital Care

Recommendation 13

The Department of Health and Fitness should ensure that hospitals receive sufficient resources to provide appropriate in-patient and/or out-patient care to persons with HIV-related illnesses.

Blood and Body Fluid Precautions

Recommendation 14

AIDS should be treated using the normal infectious disease principles applicable to blood-borne diseases. It is not deemed necessary to establish specific AIDS units or wards independent of the normal infectious disease wards. Routine dental procedures should be provided in any dental office in the province. Where conditions warrant it, dentists should have the opportunity to use hospitals for procedures or patients requiring hospital facilities.

Recommendation 15

a) Universal blood and body fluid precautions should be implemented in all health care settings, including hospitals, offices of doctors and dentists.

b) The provincial government should request that the provincial regulatory bodies for health professionals support adherence to universal blood and body fluid precautions.

Need To Know in the Health Care Setting

Recommendation 16

The only health workers who should be informed of a patient's HIV-infected status are those who provide direct care.

Testing for the HIV Antibody

Recommendation 17

Mandatory testing should not be employed as a method of detecting or preventing the spread of HIV except in relation to donations of blood, sperm, or organs and other human tissues.

Recommendation 18

Pre-test and post-test counselling should be an integral part of any HIV testing.

Recommendation 19

a) Mandatory reporting of names of HIV-positive persons to the Department of Health and Fitness should continue to be required for the regular system of testing and reporting.

b) In addition, government should provide funds for the establishment and operation of an alternative system of testing and counselling in which the names of HIV-positive persons would not be reported to the Department of Health and Fitness. This should encourage voluntary testing and a more accurate statistical reporting of the incidence of HIV in the population. This mechanism should be operated by a community-based health service.

Recommendation 20

In order to reduce risks of breaches of confidentiality in the existing system for testing, means for coded testing should be encouraged.

Recommendation 21

Reporting of an HIV-positive result should occur only after a positive confirmatory test has been received.

Drug Costs

Recommendation 22

The Government of Nova Scotia should ensure that AZT and other drugs which directly enhance an individual's ability to survive be made available free of charge to patients.

Home Care

Recommendation 23

Persons with HIV-related illnesses should be eligible for services provided through the Co-ordinated Home Care Program.

Recommendation 24

The priority assigned to applicants deemed eligible for Home Care Services should be determined on a case-by-case basis, taking into account the applicant's degree of need and whether or not the applicant has alternative potential providers of the needed services. The fact that an applicant's need for services is not likely to be continuous long-term treatment but rather temporary, and often repeated, should not affect the priority assigned to the applicant.

Recommendation 25

The Government of Nova Scotia should ensure that reasonable respite care be available for persons with HIV-related illnesses who are being cared for at home. Respite care should be provided in whatever setting is appropriate and feasible.

Community Organizations

Recommendation 26

The Government of Nova Scotia should ensure that sufficient funds are available to permit existing community organizations such as MACAIDS and the Nova Scotia PWA Coalition to expand their operations beyond the metro area; or to facilitate the development of local voluntary agencies providing educational and counselling services outside the metro area.

Support Groups

Recommendation 27

The Government of Nova Scotia should fund community organizations such as MACAIDS and the Nova Scotia PWA Coalition to permit them to provide counselling and personal support to loved ones of persons with AIDS or HIV-positive persons. A "caregivers' network" may be the appropriate vehicle to deliver the counselling or support services.

Recommendation 28

A support group for health and other care providers who work with HIV-positive persons should be set up by a collaborative effort of the Medical Society of Nova Scotia, Registered Nurses' Association of Nova Scotia and the Nova Scotia Association of Social Workers.

Palliative Care

Recommendation 29

a) The Department of Health and Fitness should provide encouragement and assistance to hospitals throughout the province to establish palliative care services for all terminally-ill patients.

b) The Department of Community Services, together with the Department of Health and Fitness, should provide encouragement and assistance to Home Care workers to enable them to offer palliative care services.

Providing Financial Support

Recommendation 30

The Department of Community Services should ensure that staff of the Family Benefits Division interpret Family Benefits Regulations in such a manner that does not deny benefits to HIV-positive persons in need and unable to obtain or maintain employment due to their medical condition/prognosis.

Recommendation 31

The cost of prescription drugs or medical supplies used on a regular, recurring basis should be classified as among the "regularly recurring needs" of Family Benefits applicants.

Recommendation 32

a) The Government of Nova Scotia should establish a province-wide minimum for Municipal Social Assistance (MSA) Basic Assistance payments and this "minimum" should be sufficient to meet the basic needs of recipients;

b) The same rules regarding limits on liquid assets should be applied to applicants for MSA as are applied to applicants for Family Benefits.

Recommendation 33

The In-Home Support Program of the Department of Community Services should extend the eligibility criteria to include all full-time lay providers of home care to eligible persons.

AIDS Education and Training in the Health and Social Service Sectors

Recommendation 34

A program should be provided by the appropriate agencies to enhance pre-service and in-service education to: physicians, dentists, nurses, home care nursing aides, first aid workers, homemakers, social service workers, hotline/helpline workers and lay providers of care.

The program should relate to:

a) basic information about HIV and AIDS,

b) the treatment and counselling of persons with AIDS and HIV-infected persons,

c) homosexual and bisexual lifestyles, and

d) infection control procedures, including universal precautions.

Appropriate community organizations such as MACAIDS and the Nova Scotia PWA Coalition may assist with the training of care providers.

Recommendation 35

The Department of Health and Fitness should establish a mechanism for responding quickly to questions from health professionals about the care of HIV-positive persons.

Research

Recommendation 36

Medical research programs should be developed within the context of the National Research Program on AIDS and should include any unique presentations of the disease in Nova Scotia.

Recommendation 37

Epidemiological surveys should be carried out to estimate the number of HIV-infected persons in Nova Scotia.

Recommendation 38

Research should be encouraged in regard to the psycho-social aspects of dealing with AIDS.

Health Care Costs

Recommendation 39

It is recommended that the Advisory Commission on AIDS develop a program in collaboration with others to monitor the costs of providing health and care services to HIV-positive persons. It is noted that there does not now exist sufficient data to allow reasonably accurate cost estimates to be provided to government. Since a number of Canadian researchers are attempting to collect this data, an attempt should be made to co-ordinate these efforts with the needs of Nova Scotia.

ENSURING RIGHTS

Amendments to the Nova Scotia Human Rights Act

Recommendation 40

The Nova Scotia Human Rights Act should be amended to include protection expressly for persons who have, who are perceived to have, or who associate with those who have a communicable disease and who pose no significant health risk as determined by public health officers.

Recommendation 41

That the Human Rights legislation be amended to preclude discrimination based on sexual orientation.

Protecting Confidentiality of Health Information

Recommendation 42

The Government of Nova Scotia should enact legislation imposing liability for breaches of confidentiality without proof of actual damage, where personal health information is released without authority of the person concerned unless otherwise authorized or required by law. Liability should be for a predetermined amount sufficiently large to act as a significant deterrent to such breaches. Statutory damages should be recoverable from anyone who was entrusted through their occupation with personal health information and is responsible for such breaches.

Warranted Disclosure of HIV Status

Recommendation 43

a) Provincial legislation should provide that, where a physician has a bonafide belief that an HIV-infected person may be dangerous to others, and that disclosure of the patient's HIV status may minimize or prevent this threat, the physician may disclose such information to the person or persons in danger or to the Department of Health and Fitness without the consent of the patient and disclosure made under such a belief shall be considered privileged and shall not amount to professional misconduct.

b) Where HIV-positive individuals are known to the Department of Health and Fitness, disclosure of their status without consent should only occur where, in the opinion of the Department, the status or condition of a person may present a threat to the health of that person or others.

Recommendation 44

Child welfare agencies should be advised of the HIV status of a child entrusted to their care so that they, in turn, might advise potential foster or adoptive parents prior to the placing or adoption of the child. Otherwise, only parents or legal guardians of children should be advised of a child's HIV status.

Quarantine and Isolation

Recommendation 45

Government should not quarantine or isolate persons having the Human Immunodeficiency Virus except in extraordinary cases. The general use of such measures in relation to HIV-positive persons would serve no useful purpose either in provision of treatment or in containing the spread of the virus. In those extraordinary cases where quarantine or isolation is deemed necessary, public health legislation should be administered, or should be amended to expressly provide procedures, in accord with safeguards of the individual consistent with modern concepts of fairness and due process.

The Presence of HIV-Infected Persons in the Educational System

Recommendation 46

The following statement of policy is recommended as a model for the favourable consideration of school boards and educational institutions:

Preamble

Transmission of the Human Immunodeficiency Virus (HIV), the generally recognized causal factor in development of the Acquired Immune Deficiency Syndrome (AIDS), is not known to occur except through sexual intercourse with an infected person or through the transfer of blood or body fluids from an infected person into the blood system of another person.

There is no evidence of infection spreading through normal casual contact. Thus, a person who has the virus does not pose any significant risk to others in most work or service settings, including the normal educational setting.

Principles for Policy in Schools and Educational Institutions

Students

The identity of a student with AIDS or infected with HIV is to be kept confidential.

Students with AIDS or infected with HIV have the right to attend regular classes unless the Department of Health and Fitness advises otherwise.

Where the Department of Health and Fitness advises that the condition of a student with AIDS or infected with HIV poses a health risk to the student or to others so that continued attendance at regular classes is not appropriate, alternative instruction should be provided on a case-by-case basis.

Teachers and Other Staff

The identity of a teacher or staff member with AIDS or infected with HIV is to be kept confidential.

Teachers and other staff with AIDS or infected with HIV have the right to continue in their regular employment so long as they are able to perform their duties according to the terms of their employment, unless the Department of Health and Fitness advises otherwise. If they become unable to perform their duties, access to all regular staff benefits should be ensured.

Teaching Programs

Information on AIDS, transmission of HIV and its avoidance, should be provided in schools and other educational institutions for the benefit of students and through in-service programs for teachers and other staff. In public schools, curricula and materials should be provided in the same way as for other school programs.

In all educational institutions, sequential, age-appropriate programs should be offered each year.

Precautions for Students and Staff Exposed to Blood or Other Body Fluids

Maintenance of minimal risk of exposure to HIV in the regular operations of schools and other educational institutions requires simple precautionary measures. In the exceptional circumstance where emergency first aid or the clean-up of blood or other body fluids is required, precautions as outlined by the Department of Health and Fitness should be followed.

PROVIDING A CO-ORDINATING MECHANISM FOR THE FIGHT AGAINST AIDS

Recommendation 47

The Nova Scotia Advisory Commission on AIDS should be a central co-ordinating agency for government policy, programs, and information on AIDS.

The Commission should also play a "linking" role among government and non-government agencies dealing with AIDS.

The Commission should be comprised of representatives from business, industry, community groups, the health and education sectors, and interested citizens.

The Commission should be established for three years, with a review of its mandate after two years.

Glossary of Terms *

Acquired Immuno-Deficiency Syndrome (AIDS)	A disease caused by a virus known as HIV, in which the body's immune system is seriously damaged, leaving it vulnerable to infections and some rare cancers that ultimately result in death.
AIDS-related complex (ARC)	ARC patients have some symptoms of AIDS, but not the "full-blown" (or "frank") disease. Symptoms may include unexplained swollen glands or fever, weight loss, or persistent diarrhea.
Amniotic fluid	A watery fluid surrounding the embryo.
Antibody	A unique protein produced by blood plasma cells to counteract or kill some specific infectious agents – viruses and bacteria.
Antibody-positive	A blood test result showing that a person has been infected with HIV at some time and has developed antibodies to HIV. It does *not* mean that a person has AIDS.
Antigen	A substance that is foreign to the body and that stimulates the formation of antibodies to combat its presence.
Asymptomatic "carrier"	A person who has had an infectious organism within the body but who feels or shows no outward symptoms.
Asymptomatic infection	The ability of certain organisms, such as viruses, to get inside a person's cells without resulting in clinical signs or symptoms that tell the person that he or she is infected.
AZT	Azidothymidine, an antiviral drug that has been shown to prolong life in AIDS patients.
Cerebrospinal fluid	The clear liquid surrounding the brain and spinal cord and filling the cavities of the brain.
Cofactors	Agents or other factors that are necessary to increase the probability for development of a disease when the basic causative agent of that disease is present.
ELISA	Enzyme-linked immunosorbent assay test for antibody.
Epidemiology	The study of relationships among various factors thought to determine the frequency and distribution of diseases in humans.
Exposure	The act or condition of coming in contact with but not necessarily being infected by a pathogenic agent.
Hemophilia	A hereditary blood condition found in males, in which minor bodily injuries can be followed by prolonged bleeding.
HIV	Human Immunodeficiency Virus – the virus that causes AIDS. Formerly referred to as LAV or HTLV-III.

* From *New England Journal of Public Policy*, Winter/Spring 1988 (special issue on AIDS).

HIV-antibody screening test	A test whose purpose is to reveal the presence of antibodies to HIV It is used on all donated blood and organs and in all medical and clinical testing programs. It is also used at alternative or anonymous test sites. If antibodies are detected, it is assumed that the individual or organ is infected.
Homophobia	The unreasonable hatred or fear of homosexuals or homosexuality.
Idiopathic thrombocytopenic purpura (ITP)	A persistent decrease in blood platelets, of unknown cause, resulting in bruising of skin and tissues.
Immune system	A system within the body which helps the body resist disease-causing organisms such as germs, viruses, or other infectious agents.
Immunosuppressed	A state of the body in which the immune system defenses do not work normally – usually as a result of illness or the administration of certain drugs used to fight cancer or prepare the body to accept transplanted donor organs.
Incubation period	The interval between infection and the appearance of the first symptom. (See "Latency.")
Infected	The state of the body in which a part of it has been invaded by a pathogenic agent that ordinarily multiplies and causes harmful effects.
Intravenous drugs	Drugs injected by needle directly into a vein.
Kaposi's sarcoma	A tumor of the blood vessels most frequently seen in the skin or mucous membranes and associated with AIDS.
Latency	A period when the virus is in the body but rests in an inactive, dormant state. (See "Asymptomatic infection.")
Lentivirus	This is a subgroup of the retroviruses. HIV belongs to this subgroup. Generally, viruses of this group replicate slowly and tend to form latent and chronic infections in their hosts.
Lymphocytes	Specialized white blood cells involved in the immune response.
Morbidity	The degree of symptomatic illness associated with an infectious organism.
Mucous membrane	A mucus-secreting membrane lining body cavities and canals connecting with the external air.
Opportunistic infections	Those diseases which are caused by agents that are frequently present in our bodies or environment but which cause disease only when there is an alteration from normal healthy conditions – for instance, when the immune system becomes weak or damaged.
Parenteral	To enter the bloodstream through a needlestick or cut.
Pathogen	Any disease-producing microorganism or substance.
Percutaneous	When exposed to large amounts of blood or body fluids when the exposed skin in chapped, abraded or afflicted with dermatitis.

Pericardial fluid	A clear serous liquid surrounding the heart.
Perinatal	Occurring in the period during or just before or after birth.
Peritoneal fluid	Fluid found in the abdominal cavity.
PGL	Persistent generalized lymphadenopathy. A persistent swelling of the lymph nodes. In AIDS, a condition of long-term generalized lymph-node swelling characteristic of the so-called AIDS-related complex.
Pleural fluid	Fluid that surrounds the lungs.
Pneumocystis carinii pneumonia (PCP)	An opportunistic infection of the lung which results in a diagnosis of AIDS.
Prevalence	The total number of persons in a given population with disease at a given point in time – usually expressed as a percentage.
Prognosis	Prediction of course and end of a disease, and outlook based on these factors.
Retrovirus	A genus of viruses which contains the enzyme reverse transcriptase and which requires the synthesis of proviral DNA for its replication.
Seroconversion	The point at which antibodies to specific antigens are produced by B lymphocytes and become detectable in the blood. "Conversion" refers to change from a negative to positive status, or vice versa.
Seronegative	Resulting in a negative reaction to a blood test – the HIV antibody test(s). If high-risk, a person cannot be assumed to be uninfected on the basis of a negative test.
Seropositive	Producing a positive reaction to a blood test – the HIV antibody test(s). A person who has a positive and confirmatory test is presumed to be both infected and infectious.
Syndrome	A set of signs and symptoms that occur together.
Synovial fluid	The clear lubricating fluid found in joints.
Vaccine	A preparation of killed, living attenuated, or living virulent organisms or part of microorganisms which can be administered to produce or increase immunity to a particular disease.
Viruses	Submicroscopic pathogens that grow and reproduce only inside living cells, thus causing disease.
Western blot	Confirmatory test for antibody.

The Acquired Immune Deficiency Syndrome is not as widespread in Nova Scotia as it is in some other places. But Nova Scotia is not isolated from the larger world, and AIDS is among us – a new and fatal syndrome for which there is now no known cure or vaccine. At this time, education and responsible behaviour are the only effective defences against AIDS.

AIDS has created an unprecedented series of challenges which test our values as individuals and as a society. AIDS challenges our sense of individual responsibility, our compassion, our sense of community and our honesty. To the extent that we meet these challenges successfully, we will develop a society which is more responsible, open, tolerant and kind.

Nova Scotia is a close-knit and caring community. The Nova Scotia Task Force on AIDS believes that as Nova Scotians come to understand the facts about AIDS and the suffering it causes, they will respond with the thoughtfulness and consideration which are the hallmark of our society, and do all they can to fight the spread of AIDS, help those who are stricken and protect the rights from which all of us benefit.